PRAXIS
HEALTHCARE SOLUTIONS

Corporate Office: (469) 209-8992
5800 Tennyson Parkway, Suite 350
Plano, TX 75024

LETTERS OF AGREEMENT AND SINGLE CASE AGREEMENTS: HOW TO AVOID DENIALS

Written by Shirley La, Staff Attorney at Praxis Healthcare Solutions, LLC

Hospitals often execute Letters of Agreements (LOA) and Single Case Agreements (SCA) with an insurance payer when the provider is not considered an in-network provider with the patient's insurance plan. LOA and SCA are usually executed at the time of admission when the patient presents with a non-contracted insurance plan. However, they may also be executed prior to admission, when the patient is ready for transfer, or at any point during the stay.

In most cases, hospitals negotiate with the payer to execute a LOA/ SCA with a defined reimbursement rate that is acceptable to both the payer and provider. Most claims are either negotiated to pay per diem, per fee schedule, or percentage of total billed charges. This seems simple enough; however, LOA/ SCA are not a guarantee of payment. There are many instances in which claims are underpaid or denied despite a provider having a LOA/ SCA on file. Below are a couple of scenarios that providers frequently encounter.

SCENARIO 1

The patient has traditional Medicare as primary and a commercial plan as secondary. Medicare Part A is exhausted prior to admission. The provider is out-of-network with the secondary. The hospital executes a LOA/SCA with the supplement to pay $1,500.00 per diem. The LOA does not mention Medicare Part B coinsurance reimbursement. The supplement pays all days at $1,500.00 per diem but does not pay the Medicare Part B coinsurance.

The LOA/SCA should be clear on its face that Medicare Part A benefits were exhausted prior to admission and the payer executing the LOA/SCA is primary.

The LOA/SCA should clearly indicate that (1) $1,500.00 per diem is not all inclusive, (2) the per diem reimbursement should be separate and in addition to Medicare Part B reimbursements and (3) the commercial plan is still responsible for the Part B coinsurance despite the per diem reimbursement for the inpatient Part A charges.

SCENARIO 2

The provider and payer enter into an agreement that states the payer shall pay a per diem rate of $1,500.00 as long as continued authorization is obtained. The LOA/SCA does not specify what level of care the authorized per diem applies to.

In the absence of a clearly specified level of care, most payers will only approve medical surgical level of care. A patient may need medical surgical level of care upon admission but could need telemetry or ICU level of care during the stay.

Providing a higher level of care means a provider should be reimbursed at a higher rate than medical surgical level-of-care. Providers, especially long-term care providers should negotiate reimbursement for numerous levels of care. Payers will indicate in their continued authorization approval letters which level of care they are approving making the calculations for expected payments simple and straightforward.

SCENARIO 3

The facility and payer enter into an agreement to pay a percentage of billed charges. The LOA/SCA states claims are to be reimbursed at 40% of billed charges.

The LOA/SCA should indicate whether level-of-care or charge stripping shall apply. Payers may decide that they will not pay a percentage of billed charges on the grounds that the facility is providing a level of care that is higher than what is necessary or that certain days are not medically necessary. A payer may also charge strip supplies, labs, and imaging services and state that they are bundled charges and are not reimbursable because CMS does not pay on those charges. A provider should specifically negotiate that the percentage of payment is for total billed charges with no exclusions.

DILIGENCE WILL HELP YOU AVOID DENIALS

While the LOA/SCA will not guarantee payment, it helps the provider know what to expect and streamlines the claim management process. The mutually signed LOA/SCA provides a legal document that outlines the intent of both parties and will provide the supporting documentation needed for appeals should payment be incorrect.

To accelerate reimbursement, a copy of the LOA/SCA should be submitted with the claim. Providers should reach out to the payer's representative who executed the LOA/SCA if any problems should arise. Claims representatives have limited information, access, and understanding of LOA/SCA and more often than not, will maintain the position that the claim was paid correctly.

Instead of executing numerous LOA/SCA, providers should aim to be in-network with insurance payers, especially if providers notice that they are executing a vast amount of LOA/SCA with a particular payer. It may be in the provider's best interest to enter into contract negotiations. This will allow for payment uniformity and will allow transparency with both the provider and payer of how a claim should be priced and paid.

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