Understanding Case-Rate Reimbursement

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Q. What is case-rate reimbursement, and how does it work in the urgent care sector?

A. *Case rate*, sometimes called *flat rate*, describes a reimbursement structure in which providers receive a flat reimbursement rate for every patient visit, no matter what service they provide.

Case-rate reimbursement means that the urgent care is contracted with the payor to receive the same reimbursement regardless of the acuity of care, whether it's the treatment of a hangnail or a complex laceration repair. ■

Q. Will the simplification of case-rate reimbursement mean that my center will save a lot of the costs of revenue cycle management?

A. Although the initial coding and charge entry is somewhat simpler, case rate has many of the same complexities of fee-for-service reimbursement and actually *adds* complexity. Billing under a case rate is not as simple as billing the payor, and in 3-4 weeks the payor remits the full amount. Generally, even under a case rate, the patient is still responsible for any copays, coinsurance, or amount put toward the deductible; thus, much of the other work of revenue cycle management is essentially unchanged. In addition, any claim billed initially as a case rate and subsequently billed to a secondary payor under a fee-for-service contract is quite complex, and is different for every payor.

A fee-for-service model involves billing (often multiple) CPT and HCPCS codes under a contracted fee schedule for those codes. With fee-for-service, higher-acuity cases typically involve billing codes with higher reimbursement, and often billing multiple additional codes specific to the complexity of the case. On the other hand, with a case rate, acuity has no bearing on reimbursement.

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"Case-rate contracts can be financially detrimental for urgent care centers that handle a high percentage of higher-acuity cases."

Although fee-for-service has been the longstanding reimbursement model in ambulatory care, many payors—such as Aetna/Coventry, Cigna, and UnitedHealthcare—no longer offer fee-for-service contracts for urgent care. However, even for these specific payors, this may vary from state to state, and by individual contract negotiations.

Many urgent care providers think a fee-for-service contract is more advantageous because they get paid for the level of care provided, but that's not always the case. Case-rate contracts can be more beneficial for urgent care centers that primarily handle low-acuity cases. Case-rate contracts, however, can be financially detrimental for urgent care centers that handle a higher percentage of moderate and higher-acuity cases. It's a matter of the cost of providing care vs the rate of reimbursement.

It is a good practice to understand what your fee-for-service contracts pay per visit. For a year (or another specific time frame), take your total dollars from adjudicated claims from a payor and divide by the number of visits. In some cases, you may be surprised to discover that your fee-for-service contracts may actually pay less, on average, than a given case rate. Yes, you may be paid a lesser amount on a specific complex case, but, overall, your average collections per visit will be more under the case rate.

If a case-rate reimbursement methodology is offered by a payor, some urgent care owners follow up with a request for a fee-for-service proposal. However, payors have generally developed specific policies for urgent care, and very few payors offer both options for urgent care centers. ■

"Detailed coding information for claims billed with a single case-rate code can be useful when planning to renegotiate with a specific payor."

Q. Is the HCPCS S9083 always the correct code to bill under a case-rate agreement?

A. HCPCS code S9083 is the case-rate code "global fee urgent care centers." Some payors request to have case-rate claims billed with code S9083 instead of billing the specific CPT codes for the services rendered. However, other payors request that you continue to bill with CPT codes despite the fact that they are reimbursing you at a flat rate.

In some instances, payors require urgent care centers to bill the CPT codes for all services rendered, and the payors then adjust everything in the back end to pay the urgent care centers the contracted case rate. Sometimes the payor wants the dollars billed for each CPT code to show on the claim, but other payors expect the additional codes to be billed at $0. The reason that some payors may prefer to have providers submit the actual CPT codes is that a blanket case-rate code also does not provide any detailed utilization information, and the payor is unable to determine the levels of care that are being provided in the urgent care. For example, in recent months, BlueCross BlueShield of New Jersey has issued a directive to its case-rate clinics to bill all claims with CPT codes instead of S9083, which was what they used previously.

If a center is planning to renegotiate with a specific payor that is contracted under a case rate, it can be very useful to have detailed coding information for claims that were billed with a single case-rate code. If a center maintains this documentation, it can be useful to show that the center is performing substantial numbers of complex services, such as complex laceration repairs, intravenous hydration, casting, and other more complex services. This can provide documentation to argue effectively that the center is offering much more than minimal care and should receive higher reimbursement under a case rate. ■