WORK PROCESS

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Single Case Agreements (SCA)
PAGE: 1 of 7	**REPLACES DOCUMENT:**
APPROVED DATE: 8/25/14	**RETIRED:**
EFFECTIVE DATE: 8/25/14	**REVIEWED/REVISED:** 9/15; 9/16; 9/17
PRODUCT: All, excluding Medicare	**REFERENCE NUMBER:** SC.UM.17.01

SCOPE:
Absolute Total Care Medical Management Department

PURPOSE:
To provide instruction on obtaining, documenting and implementing single case agreements (SCA) with non-participating health care providers authorized to provide covered services to health plan members or services not addressed in the participating provider contract.

Examples of situations that may require the use of single case agreement are:

- Emergency admissions to non-participating hospitals whether located in or out of the service area for Length of Stay projected to be greater than 5 days;
- To preserve the continuity of care with a provider following termination of a provider agreement;
- Non-participating (out of area/out of network) providers where significant financial exposure is involved;
- Specialty providers (e.g. dialysis or durable medical equipment (DME) vendor) that are unwilling to contract with the Plan
- If a participating provider introduces new services that are not contemplated in the provider agreement; and
- If a provider agreement does not contemplate a rate for a level of care that is medically appropriate for the member.

WORK PROCESS:

The requested service must first be a covered benefit and meet Medical Necessity criteria:

1. The Medical Management Prior Authorization Manager or Concurrent Review Manager and the Medical Director will confirm the need for the member to obtain out of network services:
    a. Services not available in network due to their specialized nature;
    b. Diagnostic equipment does not exist within the service area;
    c. Provider expertise on the requested procedure or treatment of a condition is not available in network;

WORK PROCESS

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Single Case Agreements (SCA)
PAGE: 2 of 7	**REPLACES DOCUMENT:**
APPROVED DATE: 8/25/14	**RETIRED:**
EFFECTIVE DATE: 8/25/14	**REVIEWED/REVISED:** 9/15; 9/16; 9/17
PRODUCT: All, excluding Medicare	**REFERENCE NUMBER:** SC.UM.17.01

2. Medical Director will initiate calls to provider liaison staff (provided by Provider Network) to confirm if the services can be performed In Network.
    a. A note will be entered into TruCare documenting the outbound call(s) confirming the need for access to out of network services/providers. If it has been determined that services can be performed within ATC covered service area/network (follow SC.UM.42 Policy);
        i. Steerage will occur to an In-network provider
        ii. If steerage is not successful, the case will be denied for services available in network with the exception of emergency admissions.
3. A SCA is not required if the non-participating provider or facility is willing to accept the applicable Fee Schedule rates (State Medicaid Fee Schedule for Medicaid contract).
    a. A note indicating acceptance of the applicable Fee Schedule will be entered in the member's record in the clinical documentation system. The note will include the date, time, name, title and contact number of the person agreeing to payment.
4. After it has been determined that the condition is medically necessary and due diligence has been performed confirming the required need for out of network services, the case must be reviewed with the Vice President of Medical Management prior to negotiating a SCA or sending the request for contracting to the Contracting/Provider Network team.

    a. This process will be initiated by a designated Provider Network Representative who has been trained in the proper procedure for negotiating a SCA, or when indicated, referring to the Provider Network Department.

    b. The Provider Network Representative will utilize Exhibit 1 (Single Case Agreement Worksheet and Contract Template) to document the negotiated rate with the health care provider/facility. The worksheet and Contract Template can be accessed through Compliance 360 (attached to policy).

    c. The Provider Network Representative will access and enter the case into the SCA tracking database. (Exhibit 2-Single Case Agreement Log)

c. If the provider is loaded in AMISYS, the Provider Network Representative will proceed to "2.e" in this process.

d. If the provider is not loaded in AMISYS, the Provider Network Representative will follow the CRM "Provider Add Process" per plan policy.

   i. The servicing provider/facility will be entered as "SP99-Unknown Physician Specialty.

   ii. A "Task" will be created in the clinical documentation system to enter the correct servicing provider/facility in the authorization.

   iii. When the new provider/facility has been created and loaded into AMISYS, the Plan Provider Set-Up team will notify the Provider Network Representative.

   iv. The Prior Authorization Manager or Concurrent Review Manager will update the servicing provider/facility in the authorization.

e. The related authorization will have a "Status" of "*Pend, Special Instructions to Claims".* The "Claim Note*"* will indicate "SCA Pending" and list the facility/provider name.

f. Upon approval of the SCA, the Prior Authorization Manager or Concurrent Review Manager will enter a "Claim Note" with instructions to Claims on how the services should be reimbursed. If the authorization is for DME, the agreed upon price will be detailed in the *"*Claim Note"

g. If a SCA is not signed within five (5) business days of the initial request, the Prior Authorization Manager or Concurrent Review Manager will outreach to Contracting area on a status. For cases requiring a SCA, the Prior Authorization Manager or Concurrent Review Manager should be requesting an extension from the requester to ensure adequate timelines for the SCA to be obtained. If a SCA cannot be obtained, the Provider Network leadership will update the SCA database as to why the SCA could not be secured, and will notify the Prior Authorization Manager or Concurrent Review Manager of the need to finalize the case. The Prior Authorization Manager or Concurrent Review Manager is to change the "Status" of the authorization from *"Pend*" to *"Approve"* and enter a note that negotiations were unsuccessful.

WORK PROCESS

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Single Case Agreements (SCA)
PAGE: 4 of 7	**REPLACES DOCUMENT:**
APPROVED DATE: 8/25/14	**RETIRED:**
EFFECTIVE DATE: 8/25/14	**REVIEWED/REVISED:** 9/15; 9/16; 9/17
PRODUCT: All, excluding Medicare	**REFERENCE NUMBER:** SC.UM.17.01

NOTE: For all **ELECTIVE** requests, No medical necessity and/or access to Out of Network provider/services is to be provided to the requester until after the SCA has been secured or until Prior Authorization Manager or Concurrent Review Manager leadership has communicated the inability to secure the SCA.

5. The **Provider Network department** will negotiate a SCA for all **non-contracted in and out-of-state facilities**, including but not limited to hospitals and skilled nursing facilities. For Outpatient Dialysis, the SCA will be completed by Medical Management if the member is hospitalized and dialysis is required as a component of the discharge plan. All routine, outpatient (not transitional from inpatient to outpatient services) the SCA will be completed by the Provider Network Department.

   a. If the estimated expense is $1,000 or above, per line item, the Provider Network Representative will complete a SCA worksheet (as listed in "2.b"), through the "Billing Address/Phone#/Fax#" section on the worksheet. Ensure to include the rationale for requesting the SCA (confirmation that services are not available In Network (what activities were taken to confirm), Medical Necessity rationale and other documentation to support Executive Management or others in having an understanding of the case and the rationale behind a SCA. The Provider Network Representative is to also enter the case into the SCA database.

   b. A hard copy of the worksheet will be delivered the same business day to a designated Provider Network representative.

   c. Negotiation will be initiated within 24 hours of identification of the need by the Medical Management Department.

   d. The Provider Network department representative will negotiate the discounted rate with the health care provider/facility for services authorized by the Prior Authorization Manager or Concurrent Review Manager.

   e. If the provider is loaded in AMISYS, the Provider Network Representative will proceed to "3.g".

f. If the health care provider is not loaded in AMISYS, the Provider Network Representative will follow the CRM "Provider Add Process" per plan policy.

i. The servicing provider/facility will be entered as "SP99-Unknown Physician Specialty".

ii. A "Task" will be created in the clinical documentation system to enter the correct servicing provider/facility in the authorization.

iii. When the new provider/facility has been created and loaded into AMISYS, the Plan Provider Set-Up team will notify the Provider Network Representative.

iv. The Prior Authorization Manager or Concurrent Review Manager will update the servicing provider/facility field in the authorization.

g. The related authorization will have "Status" of "*Pend, Special Instructions to Claims*". The "Claim Note" will indicate "SCA Pending" and list the facility/provider name.

h. The health plan Provider Network department representative will use the appropriate SCA form (Exhibit 2 or 3) to document the agreement between the plan and the health care provider for authorized services.

i. The plan President and the provider (or designee) will co-sign all SCAs with an estimated total expense of $1,000 or more.

ii. Once the SCA is executed, the health plan Provider Network department representative will forward the worksheet to the case manager.

i. The Prior Authorization Manager or Concurrent Review Manager will enter a "Claim Note" with instructions to Claims on how services should be reimbursed. If the authorization is for DME, the agreed upon price will also be listed in the "Claim Note". The authorization will remain in "Pend" status in order for the newly entered information to transfer to AMISYS.

j. If a SCA is not signed within five (5) business days of the initial request, the Prior Authorization Manager or Concurrent Review Manager will outreach to the Provider Network department and ask for a status. For

cases requiring a SCA, the Prior Authorization Manager or Concurrent Review Manager should be requesting an extension from the requester to ensure adequate timelines for the Contracting team to perform their outreach. If a SCA cannot be obtained, the Contracting team will update the SCA database as to why the SCA could not be secured, and will notify the Prior Authorization Manager or Concurrent Review Manager of the need to finalize the case. The Prior Authorization Manager or Concurrent Review Manager is to change the "Status" of the authorization from *"Pend"* to *"Approve"* and enter a note that negotiations were unsuccessful

k. The Plan Medical Management Department will maintain an electronic copy of the unsigned document and will attach it to the authorization in the member's record in the clinical documentation system.

l. If corneal transplant services are not a part of the current contract with a participating provider, or if the provider is a non-participating provider for corneal transplant services: the Provider Network department representative will review recommendations and determine if revisions are needed.

NOTE: For all ELECTIVE requests, No medical necessity and/or access to Out of Network provider/services is to be provided to the requester until after the SCA has been secured or until Prior Authorization Manager or Concurrent Review Manager leadership has communicated the inability to secure the SCA.

REFERENCES: SC.UM.42 Out of Network and Referral Services
CC.UM.01.08 Use of out of network providers and steerage
CC.UM.17 Single Case Agreements (SCA)

ATTACHMENTS:
Exhibit 1 – Single Case Agreement Worksheet
Exhibit 2 – Single Case Agreement Log

DEFINITIONS:

WORK PROCESS

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Single Case Agreements (SCA)
PAGE: 7 of 7	**REPLACES DOCUMENT:**
APPROVED DATE: 8/25/14	**RETIRED:**
EFFECTIVE DATE: 8/25/14	**REVIEWED/REVISED:** 9/15; 9/16; 9/17
PRODUCT: All, excluding Medicare	**REFERENCE NUMBER:** SC.UM.17.01

REVISION LOG

REVISION	DATE
CM changed to 'Prior Authorization Manager or Concurrent Review Manager' OR 'Provider Network Representative'. Medical Management case manager (CM) changed to 'Provider Network Representative'. Case Manager (CM) changed to 'Prior Authorization Manager or Concurrent Review Manager'.	9/3/15
Changed "Contracting Department to Provider Network" and changed "Concurrent Review Nurse to Concurrent Review Manager". Updated exhibit 1 and 2.	9/23/16
Updated "Work Process" 4. (b) to Exhibit 1 (Single Case Agreement worksheet and contract template) and (c) to Exhibit 2 (Single Case Agreement Log).	9/25/17

WORK PROCESS APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to an actual signature on paper.