Is out-of-network right for your ASC?

A s president and CEO of MedSynergies, Inc, Irving, Texas, John R. Thomas knows insurance benefits. After all, his company offers management and billing solutions to health care providers and facilities. So when Thomas opened an envelope to find his insurance company had sent him a higher-than-expected bill for spinal surgery by an out-of-network neurosurgeon, he thought the “misunderstanding” would be cleared up with a phone call. The surgeon’s office had precertified the surgery. But Thomas was in for a shock. “After 45 unenlightening minutes with the company’s support team, a personal letter, and other phone calls, the out-of-network surgery became ineligible,” he says. This despite the fact Thomas could find no “ineligible” category in his policy.

Thomas had just become a victim of the sometimes confusing world of out-of-network. Ultimately, Thomas calculated he could end up paying about $90,000 (not the $4,500 maximum stated in his policy) before reaching the maximum deductible for out-of-network service.

Despite the experience of patients like Thomas, some ambulatory surgery centers (ASCs) have turned to out-of-network as one solution for reduced payments from payors in a time of rising costs. This solution may—or may not—be for your ASC. If you do choose it, Thomas and other experts have advice for minimizing the risk of this practice.

Market influences on out-of-network

“Out-of-network” occurs when patients chooses a provider or ASC that is not included in their insurance plan. In such cases, patients usually take on greater payment responsibility. In ASCs, the term has come to mean the waiving or discounting of copayments and deductibles for patients who choose not to go in-network.

The ASC’s market determines whether out-of-network makes sense. “You need to ask whether you’re going to be able to sustain the business without a managed care contract,” says Deborah Mack, RN, MSN, CNOR, CASC, vice president of operations for National Surgical Hospitals in Chicago. That means determining the amount of managed care in the area. If, for example, 45% of the business in a particular market comes from Blue Cross, an ASC would be unable to survive financially without a contract with Blue Cross.

However, Mack adds, “There’s no reason to contract with a managed care organization unless you can negotiate a fair contract.” She says physicians can drive significant business to the center even without a contract.

Attorney Sarah Abraham, an associate with McGuireWoods, LLP, in Richmond, Virginia, says local politics can be a factor for an ASC choosing to go out-of-network: “The center might not be able to get a contract with the big payors because of competition in the area.” Local hospitals may pressure payors to shut a new ASC out of contracts.

Thomas says another potential benefit is the ability to bill the patient for the balance not paid by the insurance company. Unfortunately, this can lead to dissatisfied patients who share their misery with potential patients.

On the patient side, motivation for going out-of-network includes loyalty to a specific surgeon or respect for an ASC’s reputation.
Push-back from payors

It’s not surprising that payors frown on out-of-network tactics and are pushing back. Push-back may entail recouping payment for monies already paid, refusing to pay, and legal action. Payors may challenge the practice as an alleged kickback, insurance fraud, an unfair trade practice, or even unprofessional conduct.

Another strategy is sending the payment directly to the patient, making it harder for the ASC to collect funds because the patient may spend the money.

Payors can create fear in patients. “They send letters to patients saying if they go out-of-network, they’ll have to pay thousands of dollars,” says Mack.

Because of negotiated rates, some centers receive better payment by remaining out-of-network, says Abraham. In such cases, payors may decide to pay only in-network rates because they feel the centers are removing the motivation for patients to stay in-network. Thomas says that in some areas, such as Dallas, the in-network and out-of-network payment is similar, making patients more financially accountable. Push-back varies per state, with California one of the most active.

Choosing out of network

Going out-of-network requires careful thought. “It can be one aspect of a center’s business model,” says Abraham. “You have to determine if it’s feasible and practical.” It’s important to understand the variations of the model and to conduct a thorough business and legal risk analysis.

Out-of-network practices vary on the risk continuum. At one end are no waivers or discounts; at the other end is a full waiver for all out-of-network patients. Most ASCs going out-of-network choose a middle ground, such as a waiver or discount based on financial need with disclosure to payors or collecting the copay based on what insurance companies actually pay. More risky options include discounting to match in-network fees, with or without full disclosure to payors. The majority of legal experts recommend options that include disclosure.

Risk analysis must include the financial impact of each strategy on the bottom line and the ability to obtain other contracts. Abraham adds, “You also have to decide what you’re going to do when you don’t receive the money.” If the ASC doesn’t hold the patient accountable, payors feel the incentive to stay in-network is removed. Thomas adds that the ASC will need reserve cash to protect itself during the change in network status and that it should expect an increase in credit balances.

The state’s insurance regulations play an important role in the decision, too. Some states prohibit the practice, while others establish specific disclosure requirements. Agreement must come from the ASC’s legal counsel and governing board. Mack emphasizes the need to determine if an ASC has the physicians’ commitment to drive patients to the center when it’s out-of-network.

Reducing risk, but not risk free

In addition to basing waivers and discounts on financial need and basing the copay on the payor’s payment, several other strategies will help reduce risks. Full disclosure to payors tops the list. Disclosure needs to be communicated consistently to reduce the potential for disputes. If you don’t, “it could be considered fraudulent billing,” says Abraham. Mack recommends annual disclosure to payors and an automatic stamp on the bill. Abraham suggests either a stamp or a letter to the company stating the ASC will waive the copayment. She notes that some ASCs also do a quarterly notification letter. It’s important to describe the discount and indicate that the bill is based on usual and customary charges, not the discounted amount. ASCs should not advertise the waiver or discount, and reductions should not be made for Medicare or Medicaid patients, which would be fraud.

ASCs should have a written policy for out-of-network practices, including the process for billing and payment. Business office staff, schedulers, and physicians must be aware of the policy. The ASC’s business staff is particularly hit hard by out-of-network, as they are involved in preregistration and collections of unpaid bills.

Thomas says that education of staff and physicians is key. “You have to educate doctors about how the self-pay process works,” he says. “They also have to understand that patients usually expect little or no payment to come from them. When it does
become a patient’s dollar, the level of expectations and demands will rise and fall with the amount billed.”

Thomas warns to beware of the correlation of unexpected higher self-pay collections and patients’ satisfaction with medical procedures.

Abraham warns that even with full disclosure and no state law against the practice, there is always a risk that payors may refuse to pay or seek reimbursement after having paid.

**More customer service**

Going out-of-network can lead to unpleasant surprises for patients, even those who are well informed. The ASC business office must educate and counsel patients and do due diligence with preregistration.

Thomas says the additional work “puts more pressure on the front desk, and customer service is a lot more difficult.” The ASC sometimes end up being the customer service department for the insurance company, and collections of unpaid bills create a negative perception of the ASC. Thomas says an ASC has to ask, “Patient loyalty is great, but what is the price of loyalty when the provider is not being paid?”

**Hazy long-term outlook**

With payor push-back, will out-of-network solutions survive or go the way of sutures in glass vials?

“It was very popular for a while, but is becoming less common,” says Mack. “Managed care companies have gotten smarter.” That includes selling products that make going out-of-network very expensive, if not impossible. “It’s a model that has a certain level of risk,” says Abraham. “It remains to be seen how much payors will continue to push back on these types of waivers and reductions.”

“There’s going to be a lot of managed care turmoil in the next couple of years,” says Thomas. “I think, eventually, the status of in- and out-of-network will become a moot point, and this interim out-of-network solution will end in its current state.”

—Cynthia Saver, RN, MS

Cynthia Saver is a freelance writer in Columbia, Maryland.

**References**


**Out-of-network preregistration**

Schedulers need to collect the following information, says Deborah Mack, RN, MSN, CNOR, CASC, of National Surgical Hospitals in Chicago:

- the portions of the patient’s in-network and out-of-network deductibles that have been met
- the patient’s copay for in-network and out-of-network services
- whether there is a maximum amount of payment allowed to the out-of-network facility
- the address where the claim should be sent (it may differ from the address for in-network claims).

John R. Thomas of MedSynergies, Inc, Irving, Texas, recommends amending the registration form so the patient must sign a release for deductible status and credit authorization.