


TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
MEDICAL PRACTICE INCOME PLAN POLICY AND PROCEDURE

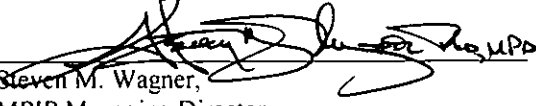
Date: 03/31/2015

Effective Date:

04/01/2015


Alyssa Cervantes
Director, Managed Care/Provider – Payer Relations


Frank Stout,
Assoc Dean/Asst VP, Finance and Administration


Steven M. Wagner,
MPIP Managing Director

Department: MC: Managed Care/Provider – Payer Relations

TITLE: Managed Care Contract Review and Execution Process

Policy#: MC 1

Policy: The purpose of this policy is to outline the procedure associated with the review and approval of managed care contracts at Texas Tech University Health Sciences Center El Paso. Managed Care contracts document a common understanding of the terms of the agreement between a type of payer of health care services and the Health Science Center, as a health care provider. These policies and procedures adhere to those set forth in the Contracting Manual for Texas Tech University Health Sciences Center, which can be accessed here: <http://www.fiscal.ttuhscc.edu/contractingmanual/main.aspx>, the Regent's Rule 07.12 on signature authority (www.depts.ttu.edu/oppol/Chapter07.pdf), and TTUHSC OP 54.01 (<http://www.ttuhscc.edu/hsc/op/op54/>). This policy shall apply to all contracts for the initial periods and for amendments or extensions thereto.

Procedure:

- 1) Managed Care Organization (MCO) forwards draft contract for provider group services to Director of Managed Care Contracts. Director reviews the draft agreement and conducts market research to evaluate proposed reimbursement rates for services. Director negotiates competitive rates based on provider supply, capacity, and in the best interest of the Institution.
- 2) Director forwards proposed agreement to Associate General Counsel for review. Director provides Counsel with the deadline for response to the MCO/execution, if a deadline was provided by the MCO.
- 3) Upon receipt of reviewed draft agreement from Counsel, Director forwards the reviewed agreement (which includes Counsel's recommendations/comments, revisions) to Dean of Clinical Affairs and Managing Director of MPIP for review. Director includes background related to the agreement (whether a department was requesting an agreement or if the request originated with the MCO, department/our provider market share information, information regarding potential volume of the agreement, departments' capacity to service the agreement, a comparison of proposed rates vs. Medicare rates or current contracted rates).


- 4) Upon receipt of reviewed draft agreement from the Dean and Managing Director, Director collates recommendations from all reviewers, composes a Contract Negotiation Memorandum, and submits to MCO.
- 5) Director follows up with the MCO biweekly and arranges a conference call to discuss recommended revisions to the proposed contract language.
- 6) When both parties have agreed to the terms of the agreement, the final version of the agreement is forwarded by the MCO to Director. Director reviews to ensure all agreed-upon terms have been reflected in the agreement and creates a Routing Sheet for El Paso Contracting Office.
- 7) Director forwards Routing Sheet, agreement background/details (including fiscal impact), and two originals of the agreement to the El Paso Contracting Office. Contracting Office forwards to Legal Counsel, Chief Financial Officer, and President for review and approval of the agreement. Once approved and partially executed by the President, Contracting Office assigns a contract number to the agreement and enters the agreement into the Contract Tracking Database.
- 8) Contracting Office mails the 2 originals of the agreement to the MCO for full execution. When MCO has returned 1 fully-executed original agreement to the Contracting Office, a Notice of Distribution, associated Routing Sheet, and fully-executed agreement is submitted to Director.
- 9) Director disseminates notification of the agreement via email (with agreement attached) to department administrators, Dean of Clinical Affairs, Credentialing Department, Managing Director of MPIP and Billing Director (for assignment of FSC number, when applicable).
- 10) For new agreements, Director schedules a workshop/training conference for clinic and billing staff with associated MCO. At the workshop, staff is apprised of MCO policies, processes, and is provided contact information for Provider Relations and Customer Service Departments. Staff is additionally trained on the MCO Provider Portal.

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Prepared by:




Alyssa Cervantes
Director, Managed Care/Provider – Payer Relations

Approved by:



Frank Stout,
Assoc Dean/Asst VP, Finance and Administration



Steven M. Wagner,
MPIP Managing Director-El Paso

Department: MC-Managed Care/Provider – Payer Relations

TITLE: Meaningful Use Attestation Administrator

Policy#: MC 2

Policy: The purpose of this policy is to outline the procedure associated with Meaningful Use (MU) Attestation for Texas Tech University Health Sciences Center (TTUHSC) El Paso. Meaningful Use is an incentive program administered by Medicare and Medicaid which provides financial incentives for providers' "meaningful use" of certified EHR technology for the purpose of improving patient care. To receive an EHR incentive payment, eligible providers must demonstrate their meaningful use of their EHR system by meeting thresholds for a number of CMS-established objectives. The Medicare and Medicaid EHR Incentive Programs are staged in three stages, with increasing requirements for participation. Providers must attest to demonstrating meaningful use every year in order to receive incentive payment *and* to avoid a Medicare payment adjustment. Program requirements may be found on the CMS website located here:http://www.cms.gov/Regulations-and-guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html. It is the responsibility of the Meaningful Use Attestation Administrator to attest on behalf of the eligible providers at TTUHSC El Paso. The process of attesting (and thus applying for the incentive payments), as performed by the Director of Managed Care/Provider – Payer Relations, is detailed in the following procedures.

Procedure:

- 1) Electronic Medical Records (EMR) Department forwards Security Risk Assessment certification (signed by applicable Leadership) annually to Meaningful Use Attestation Administrator (*Attester*), Director of MPIP Managed Care/Provider-Payer Relations department.
- 2) EMR forwards required EMR software updates Purchase Order/Contract to Attester annually.
- 3) EMR forwards required EMR screenshots to Attester.
- 4) Credentialing Department provides Attester with monthly updates from Credentialing Log, detailing new and departed provider names, department, and Medicare username and password (for new providers).
- 5) Attester runs reports at the beginning of each calendar year to develop list of providers eligible to participate in MU Programs (a provider eligible to participate in either of the MU programs is referred to as an *eligible professional* or *EP*).
- 6) Attester forwards list to EMR for measure tracking purposes.
- 7) Attester determines program in which each EP should participate (Medicare or Medicaid MU program) and registers EP in respective program.

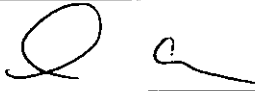
- 8) EMR forwards provider measures data to Program Analyst to create a measure dashboard for each provider upon determining provider has successfully met the program requirements.
- 9) Program Analyst forwards measure dashboard to Attester. Attester reviews to confirm program compliance.
- 10) Attester attests EPs' MU measures in program portals and records name, department, and NPI of successful attestations for future payment tracking and reference purposes.
- 11) Attester works with Credentialing to resolve any issues arising from MU attestation related to provider's credentials within 5 business days of notification of issue, and prior to attestation deadline.
- 12) Attester tracks payments received by MPIP Accounting Department for approved attestations and forwards payment information (amount of payment, applicable provider and department) to Business Affairs department for processing.
- 13) Attester additionally submits program year payment information to Chief Financial Officer for distribution.
- 14) MU Working Committee, consisting of key personnel in EMR, the Business Office and Medical Staff Office meet bimonthly to monitor progress of the above Procedure and to troubleshoot any current or anticipated issues.

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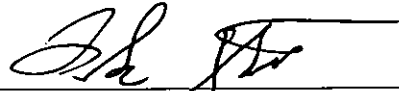
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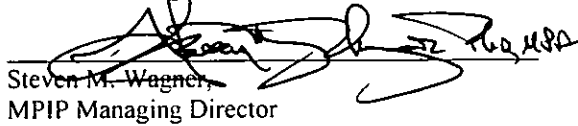
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Steven M. Wagner,
MPIP Managing Director

Department: MC-Managed Care Managed Care/Provider – Payer Relations

TITLE: Notarizing Attorney/Patients Billing Affidavits

Policy#: MC 3

Policy: The purpose of this policy is to outline the procedure associated with notarizing attorney/patients affidavits. If a patient seeks medical treatment at Texas Tech University Health Sciences Center (TTUHSC) for bodily injuries resulting from a motor vehicle accident or work related injuries and retains legal counsel, their attorney may request an official itemized billing statement from TTUHSC/the MPIP Business Office. An affidavit is produced by a Medical Billing Associate and provided to the Administrative Assistant for notarizing. The following procedures outline the process of notarizing (and thus, making official) attorney/patients billing affidavits and adhere to the institution's procedures regarding Protected Health Information found here:

www.ttuhscc.edu/hipaa/documents/manual/Privacy_Manual_090710.pdf

Procedure:

- 1) Review affidavit to verify document has been completed/filled out.
- 2) Notarize affidavit.
- 3) Record document information (including Patient account information) in the Texas Notary Record Book.
- 4) Maintain record of affidavits for department reference.