

**LOUISIANA STATE UNIVERSITY HEALTH CARE SERVICES DIVISION
BATON ROUGE, LOUISIANA**

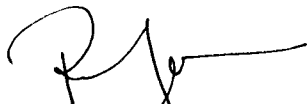
POLICY NUMBER: 8001-11

CATEGORY: Managed Care

CONTENT: Policy and Procedures to Monitor Agreements
with Third Party Payors and Managed Care Networks

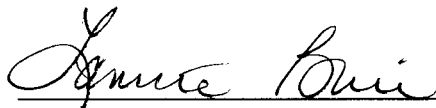
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Interim Chief Executive Officer
LSU Health Care Services Division

1.3.12
Date



Deputy Chief Executive Officer
LSU Health Care Services Division

12/21/2011
Date



Director, Managed Care Contracting
LSU Health Care Services Division

Dec. 19, 2011
Date

POLICY AND PROCEDURES TO MONITOR AGREEMENTS WITH THIRD PARTY PAYORS AND MANAGED CARE NETWORKS

Background and Purpose

It is the policy of the LSU Health Care Services Division to encourage the development of managed care agreements with private payors as a means to assure collection of revenues from patients who have this form of coverage (Policy 6509-08). The purpose of this policy and associated procedures is: (1) to promote the implementation of such agreements in a manner that maximizes revenues to the hospitals; (2) to assure the availability of information needed to periodically evaluate the profitability of managed care agreements, and (3) to specify responsibility for development and analysis of information on the profitability of such agreements that support informed management decisions on the continuation, cancellation or renegotiation of managed care agreements.

The need for this policy arises because of a new type of contract into which the system and the hospitals are entering. The most familiar contracts in the past have been ones in which the payor and the provider network are identical, e.g., State Group Benefits or Blue Cross. However, many national PPOs build provider networks which they market to multiple payors. Under a contract with Multiplan, American Life care or Up and Up, for example, hospital rates are specified in our agreement, and the PPO then extends those rates to payors, often specific employers, as it sells its product (its contracted provider network) to them. Consequently, when a patient seeks service in HCSD facilities, and the payor information is entered into our patient accounting system, the identity of the PPO network through which the payor may take a discount either is not recorded or is not known at all. In fact, the identity of the PPO may not be known until the EOB is received identifying the contracted network through which the payor is taking a discount.

This situation creates a need for an automated method to link a payor, a contracted network and particular patients in order to generate information on our experience under each managed care agreement.

Policy

It is the policy of the LSU Health Care Services Division that all agreements with Third Party Payors should be administered in such a manner as to maximize reimbursement to the hospitals and to permit the ongoing assessment of those agreements using data routinely accumulated in the patient accounting and other information systems during the routine administration of a patient stay or outpatient encounter.

Procedures to implement this policy, at a minimum, shall assure that automated data are available to permit the association of patient stays or encounters with any agreement under which payment may be due and to identify any action by the hospital which may have the potential to result in the denial or reduction of payment that may otherwise be due under the agreement. It shall be the responsibility of the LSU HCSD Managed Care Section, to promulgate amendments, as needed, to the procedures contained herein, which are designed to implement this policy.

Procedures

Approach:

The assignment of unique *service codes* to managed care agreements is essential in order to systematically associate specific managed care agreements with particular instances of patient utilization, either inpatient stays or outpatient encounters. These service codes are necessary for the generation of periodic ad hoc reports for such purposes as:

- a. Monitoring the volume and type of utilization
- b. Monitor the incidence of denials based on utilization review
- c. Determining the accuracy of payments
- d. Performing financial analysis and modeling to assess the viability of the agreement
- e. Monitoring for improper "Silent PPO" activity

Assignment of Service Codes:

For each managed care agreement that is entered into by LSU - HCSD or any one of its hospitals, the HCSD Managed Care staff will coordinate the assignment of two unique service codes for that agreement through the Application Support section, Information Services, LSU HCSD. These are:

Contractual Adjustment Service Code

Utilization Review Denial Code

Use of Service Codes:

These codes will be used by appropriate hospital personnel who are responsible for insurance collections and adjudication of claims to post the appropriate allowance, as follows:

1. Contractual Adjustment Service Code - This code will be used to post the contractual allowance for a particular agreement.

It is important to note that, with some managed care agreements, contractual allowances are written off to the Contractual Adjustment service code by the system; however, this can occur only when information about the applicability of the managed care agreement for the particular patient is known and entered into the system. *These procedures apply when the applicability of the agreement becomes known and the information is not already in the system. The most common instance of this will occur when the applicability of the agreement to a particular patient is learned only when an EOB is received in the patient accounting department.*

2. Utilization Review Denial Code - This code will be used to post the appropriate allowance that results when the utilization review requirements associated with a particular agreement have not been met, and the payor declines to pay or reduces the amount of the payment as a penalty.

Responsibility:

The use of the Contractual Adjustment Service Code and the Utilization Review Denial Code consistent with this policy and the associated procedures shall be the responsibility of the Patient Accounts Manager, under the general supervision of the Fiscal Officer or Chief Financial Officer (CFO).

Reporting and Analysis:

The LSU HCSD Managed Care section shall produce periodic reports to monitor managed care contracts and compliance with this policy and its associated procedures. The HCSD Managed Care section, in cooperation with the hospitals, shall also develop appropriate analysis of the experience of the hospitals under managed care agreements.

Effective Date:

This policy will become effective immediately upon signature by the Chief Executive Officer of the LSU Health Care Services Division.