MDA20-105 Department of Cardiology
Departmental Review

EXECUTIVE SUMMARY

The Department of Cardiology serves as the first onco-cardiology unit in the world to provide comprehensive cardiac care to patients with cancer, generating $24 million in professional revenue in FY19. The department resides within the Division of Internal Medicine and has three main mission focus areas: Clinical, Research, and Education. The department employs approximately 41 FTEs, including 17 faculty members.

The Department has strong controls in place to ensure professional charges are captured for services provided. Specifically, the Department has a subject-matter expert on staff to monitor the charge capture process. Additionally, the Department demonstrated strong financial stewardship, by ensuring funds are spent within budget an on business related activities. We did; however, identify areas of improvement as outlined below:

Area	Key Observations Noted
IT Asset Management	• IT asset protection • IT asset inventory and recordkeeping • IT assets in excess of policy
Personnel Management	• Extramural leave records
Grants Management	• Allocation of shared project costs • Effort reporting • Progress reports
Charge Capture	• Diagnosis codes due to current Epic configuration • Establishment of contracts with non-MD Anderson facilities

The Department has been proactive in addressing the observations as they arose throughout the audit. Less significant recommendations have been communicated to management under a separate cover.

Management Summary Response:
Management agrees with the observations and recommendations and has developed action plans to be implemented on or before August 31, 2020.

Appendix A outlines the methodology for this project.

The courtesy and cooperation extended by the personnel in the Department of Cardiology are sincerely appreciated.

Sherri Magnus

Sherri Magnus, CPA, CIA, CFE, CRMA, CHIAP
Vice President & Chief Audit Officer
April 10, 2020

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Detailed Observations

ASSET MANAGEMENT

Asset management includes acquisition, inventory, and disposal of assets. The department had approximately 270 assets during the period; however, has not prioritized asset management protection and monitoring of its information technology (IT) assets. Without proper asset management, the Department's assets are at risk for loss, theft, misuse. Additionally, valuable data could be lost, stolen, or exposed, and fines or penalties could result.

Observation 1:
Protect Information Technology (IT) Assets   *RANKING: HIGH*

The Information Resources Security Operations Manual (IRSOM) requires the protection of desktops, laptops, and mobile computing devices that view or store confidential information. As of October 8, 2019, we identified approximately 70 IT devices (26% of the department's assets) that did not contain sufficient protective measures, of which 12 were disclosed to Materials Management Services as having Patient Health Information (PHI). Without protective measures, sensitive information could be accessible to unauthorized individuals.

According to management, once this was brought to their attention, 39 IT devices have been sent to the warehouse for decommissioning, 9 have been identified as missing, and 1 has had protective measures installed. Management is addressing the 21 remaining IT devices which are unprotected, including 3 disclosed as containing PHI.

Recommendation:
Management should take immediate steps to sufficiently protect IT devices and properly report the missing items to appropriate departments. Management should also implement a monitoring process to ensure that IT devices continue to be protected. If protective measures cannot be implemented for some devices, they should be decommissioned.

Management's Action Plan:
Executive Leadership Team Member: Dr. Anita Deswal, Department Chair
Division/Department Executive: Christine Reid, Department Administrator
Owner: Kawana Guillory, Operations Manager
Implementation Date: Implemented - February 2020

The Department of Cardiology has implemented this recommendation. It will monitor the protection of all IT assets by generating periodic reports. Reminders will be sent to employees as needed to ensure that assets remain fully encrypted. As of this date, 56 items have been decommissioned and sent to the Pawnee Warehouse. AirWatch encryption has been installed in six devices. However, eight devices were unaccounted for and reported to 4-INFO as missing via eight individual incident reports. A missing property summary report was filed with UT Police on February 28, 2020, under case number 2020-0228-003.

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Observation 2:
Improve Inventory and Recordkeeping Over IT Assets   *RANKING: HIGH*

As of October 2019 (unless otherwise noted), we identified the following areas where asset controls should be enhanced:

- The department was unable to initially provide 2 portable IT assets for inspection during our audit; however, they subsequently provided photographic evidence of existence. One asset is a laptop that contains PHI, according to CEMS.
- 23 assets, consisting of iPads, iPhones, laptops, and printers were purchased and delivered to the department, but were never assigned to an individual. Subsequent to discussions with management, the department sent 10 assets to the warehouse for decommissioning, identified 6 items were missing, and re-assigned 7 in CEMS.
- Records were not updated for 13 assets to reflect the current individual assigned; however, the department subsequently updated all records to the appropriate user.

The Information Resources Security Operations Manual (IRSOM) and the Asset Control Manual (ACM) provide requirements for oversight and protection of Institutional assets. Requirements include reporting of missing assets and maintaining accurate inventory records. Also, institutional guidelines encourage optimizing state resources including equipment. Without adequate controls over assets, there is an increased risk that theft or losses may occur and not be detected in a timely manner.

Recommendation:
Management should strengthen controls to ensure that all assets are accounted for and accurately recorded.

Management's Action Plan:
Executive Leadership Team Member: Dr. Anita Deswal, Department Chair
Division/Department Executive: Christine Reid, Department Administrator
Owner: Kawana Guillory, Operations Manager
Implementation Date: Implemented - March 2020

The Department of Cardiology will strengthen internal controls to ensure that all assets are accounted for and accurately recorded by maintaining a departmental database. Unused assets will be sent to the Pawnee Warehouse for decommissioning as needed with records acknowledging "equipment picked up" being kept in the Department. A monthly review of inventory records will be conducted to ensure information is up-to-date. The March monthly report was prepared on March 2, 2020.

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Observation 3:
Address Excessive IT Assets   ***RANKING: HIGH***

The Department has not continuously monitored the number of IT assets assigned to or purchased for each employee. We identified 8 employees who possessed between 4 and 8 assets each. If department does not enforce IT asset limit, overspending of department funds and misuse of assets may occur. Institutional policy stipulates that non-faculty users can have up to three devices while faculty can have up to four devices.

After bringing the above to management's attention, management requested assets in excess to be returned and decommissioned. As a result, 4 employees no longer possess an excessive amount of assets.

Recommendation:
Management should evaluate the number of IT assets currently assigned to each employee, and takes the necessary actions to ensure compliance with institutional policy. Furthermore, management should implement monitoring procedures to ensure continued compliance in the future.

Management's Action Plan:
Executive Leadership Team Member: Dr. Anita Deswal, Department Chair
Division/Department Executive: Christine Reid, Department Administrator
Owner: Kawana Guillory, Operations Manager
Implementation Date: Implemented - February 2020

The Department of Cardiology has implemented this recommendation. We will continuously monitor assigned asset limits to ensure all are in compliance with Institutional policy. As of this date, no Cardiology employee exceeds the number of allowable devices individually assigned. Our Operations Manager will act as point of contact for all future requests for devices to ensure full compliance with Institutional Policy.

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PERSONNEL MANAGEMENT

Kronos is the official institutional time and attendance management system. Effective personnel management includes, but is not limited to, the weekly review and approval of timecards and the accurate and timely recording of extramural (EXT) and employee leave.

Observation 4:	
Enhance Extramural Leave Process	***RANKING: MEDIUM***

Extramural leave is granted annually to eligible faculty members to pursue outside professional activities or interests with or without personal financial gain. Per policy, extramural leave must be recorded in Kronos and may not exceed 30 working days in any fiscal year without prior approval. We reviewed 30 trips (145 days) during FY19 and found that EXT days were not accurately recorded in Kronos for 8 (26%) trips.

Institutional Policy requires extramural leave to be accurately recorded in Kronos for all acceptable activity. Additionally, extramural leave must be approved in advance by the department chair. When extramural leave is not managed properly, Kronos leave balances may be incorrect and the 30-day extramural leave limit may also be exceeded.

Recommendation:
The Department should enhance processes to ensure accurate recording of extramural leave in Kronos. Management should coordinate with Human Resources to adjust paid time off balances, where appropriate. Additionally, the Department Chair should approve all extramural leave in advance.

Management's Action Plan:
Executive Leadership Team Member: Dr. Anita Deswal, Department Chair
Division/Department Executive: Christine Reid, Department Administrator
Owner: Kawana Guillory, Operations Manager
Implementation Date: August 31, 2020

The Department of Cardiology is currently working with Faculty Academic Affairs to ensure extramural leave policies are being interpreted correctly for accurate recording in Kronos. Extramural leave in the Department of Cardiology will be approved in advance by Department Chair and Department Administrator. It should be noted that no Cardiology faculty member has ever exceeded the 30-day extramural leave limit without prior approval from Executive Leadership. We had to cancel our scheduled in-service with FAA, all Cardiology faculty and the admin support team for Friday, February 28, 2020, due to extenuating circumstances following a Houston water main break. However, we will be rescheduling this meeting at the earliest opportunity in March 2020.

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GRANTS AND CONTRACTS MANAGEMENT

Grants management relates to the administrative tasks required to comply with the financial, reporting, and program requirements of federal, state, and private sponsors, as well as institutional policies. It includes, but is not limited to, effort reporting, grant reporting, and shared cost allocations. The Grants process consists of collaboration between the Department, Office of Sponsored Programs (OSP), and Grants and Contracts Accounting (GCA).

Observation 5:	
Allocate Shared Project Costs	**RANKING: MEDIUM**

Lab supplies and expenses are shared among projects, which include Federal, and Private Industry sponsors, and are not consistently allocated to the related grants. Federal regulations require that such costs be allocated to a project in proportion to the associated activities. When costs are not allocated accordingly, federal projects may incur costs not associated with the project.

Recommendation:
Management should develop and implement a reasonable cost allocation methodology for shared lab supplies.

Management's Action Plan:
Executive Leadership Team Member: Anita Deswal, MD, Department Chair
Division/Department Executive: Christine Reid, Department Administrator
Owner: Christine Reid, Department Administrator
Implementation Date: Implemented - February 2020

The Department of Cardiology will work with Research Lab Coordinator to develop a cost allocation methodology for shared lab supplies.

Observation 6:	
Improve Effort Reporting	**RANKING: MEDIUM**

In some instances it appears effort is certified based on payroll distribution instead of actual time spent on a project. According to federal guidelines and the Institution's Effort Certification policy, employees must certify the accuracy of effort spent on sponsored projects. While payroll distribution describes the sources of an employee's salary, effort certification describes the employee's actual effort on a project.

Non-compliance with federal regulations relating to effort reporting may result in penalties and fines and possible loss of future funding for the Institution.

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Recommendation:
Management should enhance controls to ensure that effort reflects actual time spent on projects.

Management's Action Plan:
Executive Leadership Team Member: Dr. Anita Deswal, Department Chair
Division/Department Executive: Christine Reid
Owner: Susan G. Ray, Sr. Financial Analyst
Implementation Date: Implemented - February 2020

In an effort to enhance controls, an additional step was implemented for reporting. After the Effort/ECC care statements are certified, an additional review of comparing certified effort, committed effort, and paid effort will be performed. If warranted, adjustments will be made before the effort card is processed.

Observation 7:
Submit Progress Reports Timely   *RANKING: MEDIUM*

The department has not consistently submitted progress reports for its federal grants within the specified timeframe. For 8 active grants during the period, 3 progress reports were submitted after the due date to Office of Sponsored Programs (OSP), which is responsible for submitting reports to the sponsor. According to Management, the Principal Investigator (PI) did not notify the Department of progress report due dates timely. Noncompliance with reporting requirements may impact future federal funding.

Recommendation:
The department should collaborate with OSP and Grants and Contracts to ensure progress reports are submitted timely as required.

Management's Action Plan:
Executive Leadership Team Member: Dr. Anita Deswal, Department Chair
Division/Department Executive: Christine Reid
Owner: Huyen Tran, Grant Program Manager
Implementation Date: Implemented - February 2020

The delayed progress reports were from NIH Subcontracts. Progress reports were submitted on time for those NIH grants whereby MDACC was the Primary Institution.

Subsequently, the Department has developed a database of all sponsored research projects which identifies timelines and reporting deadlines. Reminders will populate on the Outlook Calendar for the Grant Program Manager who will report to the Department Administrator. Sub-award notification reminders will be issued 90 days before end of project period to ensure the PI has ample time to submit his progress report to the Primary Institution.

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REVENUE CYCLE

The revenue cycle encompasses the identification, management, and collection of patient service revenues. Charge capture is the process by which a billing record is created for technical and professional services rendered to patients, and is a key component of the revenue cycle. Charge capture reconciliation is the process by which there is validation of a completed charge.

Observation 8:
Ensure Accuracy of Diagnosis for Cardiology Billings   *RANKING: HIGH*

Department management expressed concern about the manner in which Epic captures the diagnosis for certain cardiology procedures. Upon further review, we confirmed that $5.6 million in gross charges for echocardiograms was billed for FY19 with a primary cancer-related diagnosis code. For cardiology procedures, Epic pulls the diagnosis code from the associated cancer diagnosis, instead of pulling it from the reason for the visit with the cardiologist. Without a cardiology-related primary diagnosis code, these charges could be denied by the insurance provider.

Recommendation:
The Department should collaborate with the EHR team, Coding, and Institutional Compliance to ensure the accuracy of the diagnosis code for all cardiology procedural billings. Consideration should be given to modifying the Epic build to ensure cardiology procedures are supported by a cardiology-related primary diagnosis code.

Management's Action Plan:
Executive Leadership Team Member: Dr. Anita Deswal, Department Chair
Division/Department Executive: Christine Reid, Department Administrator
Owner: Mona Williams, Manager of Charge Capture
Implementation Date   Implemented – January 2020

*This issue of accuracy of diagnosis for Cardiology billings was identified as an "EPIC" build problem, was discovered by management in the Department of Cardiology following EPIC go-live in March 2016, and was subsequently reported to the EHR team, Coding, PBS Reimbursement, and Institutional Compliance and leadership in the Division of Internal Medicine. This issue is specific to all diagnostic echocardiogram procedures performed by the Department of Cardiology, which are **order** driven. Unfortunately, the EPIC charge capture build is not set up to route the correct reason for the visit or the definitive diagnosis to the charge encounters. Instead, the router is set up to pull the diagnosis code/reasons for the visit from the "associated diagnosis" code on the order set, which is routinely the admitting cancer diagnosis.*

The Department of Cardiology will continue to collaborate with the EHR team, the EPIC team, the PRS coding team, the Compliance team as well as the Legal Services team to help facilitate the needed changes in the EPIC build to accurately capture the cardiac indications/cardiac reasons for the procedures.

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<u>Observation 9:</u>
Expectations of 3rd Party Surgical Sites   *RANKING: Medium*

During our review, it came to our attention that the Department of Cardiology is performing surgical procedures on MD Anderson's patients at other non-MD Anderson facilities. Currently, the Institution does not have a formal document outlining what procedures will be performed, who's responsible for deciding which procedures will be performed externally, and the responsibilities of all parties involved. Without documented expectations, there is no way to outline roles and responsibilities for both parties while ensuring accountability for the activities performed.

<u>Recommendation:</u>
Management should continue its efforts to coordinate with appropriate individuals at the Institution to determine if formal expectations should be developed and communicated when surgeries and other services are performed at 3rd party surgical sites. Also, the Department of Cardiology should provide Physician Referral Services, Legal Services, Compliance, and others as appropriate, the names of all physicians, along with the services they are providing at non-MD Anderson facilities.

<u>Management's Action Plan:</u>
Executive Leadership Team Member: Dr. Anita Deswal, Department Chair
Division/Department Executive: Christine Reid, Department Administrator
Owner: Mona Williams, Manager of Charge Capture
Implementation Date: Implemented - February 2020

The referenced recommendation is noted. Coordination with appropriate individuals at the Institution will be continued. The Cardiology physicians who provide professional services at non-MDACC facilities for MDACC patients are documented in EPIC, posted to billing area 688 as offsite charges, and recorded with PRS by provider, CPT codes, patient MRN, dates of service, and professional charges. As mentioned in the recommendation, a separate summary report of CPT codes and described procedures performed by physician will be provided to Legal Services, Compliance, and others as appropriate as part of the continued discussion.

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Appendix A

Objective, Scope and Methodology:
The objective of this review was to provide a general assessment of the financial, administrative, and compliance controls within the Department. Testing periods varied based upon the area or process reviewed; however, all selected transactions occurred between September 2018 and December 2019, unless otherwise noted below.

Our methodology included the following procedures:

- Interviewed key personnel and reviewed relevant organizational policies to understand financial and administrative processes within the Department.
- Reviewed grant administration processes related to effort reporting and certification; allowable expenditures; cost allocation; sub recipient monitoring; timely progress reports; and use of material transfer agreements.
- Reviewed the results of the Department's 2019 physical inventory and assessed processes and controls over assets.
- Reviewed IT assets reported as non-encrypted and validated current status.
- Tested procurement card transactions and reconciliations for compliance with institutional guidelines.
- Reviewed documentation to ensure required monthly certification of selected expenditures.
- Reviewed grant and non-grant account activity to determine whether deficit balances were properly resolved.
- Examined timekeeping and leave records to determine if institutional leave management guidelines were followed.
- Reviewed and evaluated Lab controls and processes.
- Tested charge capture processes including completed orders, open/closed encounters, and work queues.
- Reviewed outside surgeries performed at other hospitals during the audit period.
- Tested expenditures of Chairman's funds for allowability and appropriateness.

Our internal audit was conducted in accordance with the *International Standards for the Professional Practice of Internal Auditing.*

Number of Priority Findings to be monitored by UT System: None
A Priority Finding is defined as "*an issue identified by an internal audit that, if not addressed timely, could directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole.*"

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