Office of Internal Audit

January 8, 2013

Dr. Kirk A. Calhoun, President
The University of Texas Health Science Center at Tyler
11937 U. S. Hwy 271
Tyler, TX 75708

Dear Dr. Calhoun:

As part of our FY 2013 Audit Plan, we completed the Patient Access Audit, which specifically focused on patient registration and insurance verification processes. The objective of the audit was to determine whether patient registration processes and systems are adequate to support timely, accurate and efficient billing.

We found that overall, patient registration processes and systems are adequate to support timely, accurate and efficient billing. Although we found processes to be adequate, we identified several opportunities for improving processes and controls. Detailed results are included within the report.

This audit was conducted in accordance with guidelines set forth in The Institute of Internal Auditor's *International Standards for the Professional Practice of Internal Auditing.* We appreciate the assistance provided by management and other personnel and hope the information presented in our report is helpful.

Sincerely,

Kris I. Kavasch
Director of Internal Audit

Enclosure

cc:

Dr. Kenneth I. Shine, UT System Executive Vice Chancellor for Health Affairs rbuckingham@utsystem.edu
Mr. J. Michael Peppers, UT System Chief Audit Executive systemauditoffice@utsystem.edu
Mr. Richard St. Onge, UT System Associate Vice Chancellor for Health Affairs richardstonge@utsystem.edu
Mr. Vernon Moore, Vice President, Chief Business and Finance Officer vernon.moore@uthct.edu
Ms. Melissa Ellis, Director of Business Operations melissa.ellis@uthct.edu
Ms. Carrie Marsh, Patient Access Manager carrie.marsh@uthct.edu
Ms. Anne Heitke, UT System Audit Manager aheitke@utsystem.edu
Legislative Budget Board - ed.osner@lbb.state.tx.us
Governor - internalaudits@governor.state.tx.us
State Auditor's Office - iacoordinator@sao.state.tx.us
Sunset Advisory Commission - sunset@sunset.state.tx.us

The University of Texas Health Science Center at Tyler
Patient Access Audit
FY 2013

January 8, 2013

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT TYLER
OFFICE OF INTERNAL AUDIT
11937 US HIGHWAY 271
TYLER, TX 75708

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Audit Report

Executive Summary

This audit was completed as part of our FY 2013 Audit Plan. The objective of the audit was to determine whether patient registration processes and systems are adequate to support timely, accurate and efficient billing. Audit procedures focused on Patient Access front-end processes for registering patients and verifying insurance, which have a direct impact on effective billing.

Overall, patient registration processes and systems appear to be adequate to support timely, accurate and efficient billing. However, the following issues were identified that need management's attention:

The most important issue observed concerns:

- The need for the Director of Business Operations to continue to work with IT and the Meditech Billing and Accounts Receivable (BAR) module vendor to resolve system and manual process issues that result in duplicate patient accounts within the system. The duplicate account issues have been ongoing for over a year and although management has attempted to work with the vendor to resolve the issues, little to no progress has been made in resolving them. Duplicate accounts cause a vast amount of rework and inefficiencies in the registration and billing processes.

Other issues are as follows:

- The Patient Access Manager needs to continue in the process of developing written policies and procedures for key revenue cycle activities such as patient registration, insurance verification, pre-authorization, precertification, medical necessity, scheduling, quality assurance and professional behavior/customer service for employee guidance and these need to be added to the UTHSCT Hospital and MSRDP Operations Manuals.
- The Director of Business Operations, Patient Access Manager, Patient Financial Services (PFS) Billing Supervisor, and Director of Case Management need to collaborate to evaluate the cost vs. benefit of extending insurance coverage verification to services other than inpatient admissions and certain orders.
- The Training Specialist II needs to formally document the training program requirements and management's approval of the program. Processes need to be implemented for identifying and documenting employees that need to be trained and employees trained.
- The Director of Business Operations needs to implement tools and/or processes for monitoring registration staff performance.
- When registration errors are identified, the Director of Business Operations needs to implement processes for resolving the root cause of the errors and deficiencies in addition to correcting the error or deficiency to get the claim submitted.

The University of Texas Health Science Center at Tyler
Patient Access Audit
FY 2013

Background

This audit was completed as part of our FY 2013 Audit Plan in the area of Operational Audits. The Patient Access division of Patient Financial Services is responsible for front-end patient revenue cycle processes for the institution. At UTHSCT there are currently sixty-four full time and thirteen PRN employees within Patient Access including one manager, one training specialist and three supervisors.

A patient's first encounter with the institution's revenue cycle typically occurs with patient scheduling and registration processes. It is where the patient forms his or her first impressions of the facility and where key data for the billing process is first collected. Good business practices in front-end revenue cycle processes can have a positive impact on cash flow, reduce operating costs, reduce rework needed in the business office, and improve customer satisfaction.

The Patient Access division is responsible for registering patients throughout the institution, with exception of four certain offsite locations where registrations are handled by staff members who perform registrations as well as other job responsibilities and report to managers outside of the Patient Access Department. The registration process involves the collection and documentation of all patient demographic, insurance and provider information. Staff members are responsible for copying patient's identification documents and insurance cards, verifying insurance eligibility in certain situations, collecting co-payments and pre-deposits (self-pay patients), providing various required disclosures and obtaining a signature acknowledgment from the patients. In addition, staff members schedule appointments and process external referrals. Financial Counselors who report to the Director of Case Management perform insurance verification and pre-authorization for inpatient admissions and certain tests and procedures considered to be higher dollar or the type that generally require pre-certification. Insurance verification is not performed for office visits and certain other procedures. These processes and related data obtained serve an integral part in effectively and efficiently billing patient accounts.

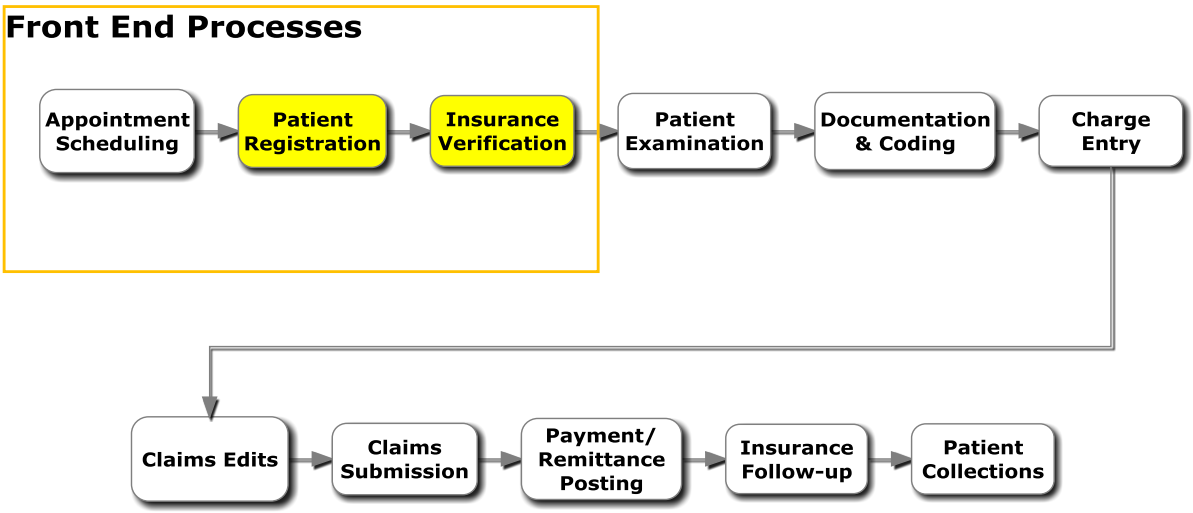
Audit Objective

The objective of the audit was to determine whether patient registration processes and systems are adequate to support timely, accurate and efficient billing.

Audit Scope and Methodology

The scope of the audit was patient registration processes in place in FY 2013 (September 1, 2012 through December 5, 2012). FY 2012 historical data was reviewed as needed to validate certain processes or documentation. Although front-end revenue cycle processes include scheduling, registration and insurance verification we focused our work in the areas of registration and insurance verification due to the impact these areas have on timely, accurate and efficient billing.

The Patient Revenue Cycle Process Diagram below reflects the front-end revenue cycle processes covered in this audit and how they relate to the entire cycle.



To accomplish the audit objective, we performed the following procedures, among others:

- Interviewed key management and personnel to identify applicable policies, procedures and practices in place
- Reviewed applicable policies and procedures and compared these with practices in place
- Physically observed, reviewed and evaluated patient registration processes for the Family Practice Clinic, Internal Medicine Clinic, Oncology, Emergency Room and Central Registration - Radiology, Lab, and Inpatient Admissions
- Reviewed documentation and evaluated whether insurance verification, pre-authorization and pre-certification processes were adequately performed and documented in the system for a sample of transactions
- Reviewed documentation and evaluated processes for correcting front-end registration errors that affect billing
- Reviewed and evaluated the staff training program and resulting documentation
- Reviewed and evaluated the method for resolving and documenting patient complaints concerning front-end registration processes

We conducted our audit in accordance with guidelines set forth in The Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing.*

Audit Results

Overall, patient registration processes and systems appear to be adequate to support timely, accurate and efficient billing due to processes or systems in place for training personnel, capturing and recording patient demographic information and verifying insurance coverage. Our opinion is based on the following:

An active formal staff training program that provides initial and periodic training is integral to effective front-end registration processes. UTHSCT has on staff an experienced designated trainer who provides patient registration training to all new hires and refresher training to any staff member who needs or requests it. Newly hired employees who perform patient registration functions must attend a comprehensive registration training session and meet competency requirements prior to performing registration duties. Patient Access Representatives interviewed were very satisfied with the training program and level of training they have received. Ultimately, the comprehensive and effective training program in place promotes timely, accurate and efficient billing by providing knowledgeable and skilled staff for performing patient registration functions.

Patient Access registration staff and areas observed displayed good customer service, job knowledge, and decision-making skills. The patient areas observed were staffed with check-in and check-out personnel who have been cross trained to perform either function which allows more flexibility in serving the patients and helps to ensure good process flow. When observed there were two employees available at each site to check in patients, which also helps with patient process flow. Although there are no written registration policies and procedures, employees observed followed registration procedures in accordance with the training provided. Based upon our interviews and observance of procedures, we believe staff understand their level of knowledge and authority and do not hesitate to contact the appropriate management when decisions are needed that are outside their level of knowledge or authority.

The patient registration process and the patient information system is not overly complex for registering patients and the system includes certain fields for required demographic information. Certain key demographic fields are set as required and the system will not allow the employee to continue until complete. Certain prompts are set up for other important information such as Medicare Secondary Payor that will not let the employee continue until questions are completed. These front-end processes and controls help to promote effective and efficient billing.

Insurance verification performed on the front-end ensures the accuracy of insurance information and promotes timely, accurate and efficient billing and reduces rework needed due to inaccurate data. Financial Counselors who report to the Director of Case Management perform insurance verification, pre-authorization and pre-certification for hospital admissions and higher dollar tests and procedures ordered. Processes are in place for insurance verification, pre-authorizations and pre-certifications to be performed timely for the services noted above and results are adequately documented within the patient information system for billing reference.

Although patient registration processes and systems were generally deemed to be adequate for effective billing, in the course of reviewing documentation and evaluating processes we identified the following areas for improvement:

Duplicate Accounts

The most important process and system issue observed involves the creation of duplicate patient accounts within the Meditech Billing and Accounts Receivable (BAR) module. Based upon

discussions held with key management and staff and review of certain reports we believe there may be both Meditech system and manual process errors which result in duplicate patient accounts for numerous patients in the Meditech BAR system. These errors have been occurring for over a year and cause a vast amount of rework and inefficiencies in the registration and billing processes. Although management has attempted to work with the vendor to resolve the issues and these ongoing system issues have been reported to the vendor numerous times during the past year, none of the issues have reportedly been adequately addressed by the vendor. In addition, in the past year UTHSCT management has not successfully identified the root cause of the problems to effect resolution but has developed workarounds for deleting the duplicates and moving charges to get the account billed, which is very important for prompt reimbursement. Although this process helps to ensure bills submitted are accurate, eliminates duplicate accounts and promotes timely claim filing it does not correct the system or manual process deficiencies.

Recommendation #1: To ensure the integrity of the patient information system and related data, we believe it is critical to perform a thorough examination of the system, rules set up in the system by internal management and manual processes to identify and correct system and process errors that are causing duplicate patient accounts in the Meditech system. The Director of Business Operations should ensure that problems reported to the vendor are escalated for resolution and internal resources should be allocated for reviewing and resolving system and process issues that are causing the creation of duplicate patient accounts.

Management's Response: The Director of Business Operations will proactively work toward identifying causes for the duplicate accounts by performing account testing within the system and working with the Meditech vendor to identify and resolve system and process issues that are causing the duplicate account errors.

Implementation Date: August 31, 2013

Policies

UTHSCT has informally implemented procedures for front-end revenue cycle operations and the Patient Access Manager has initiated a process for developing operations manuals for each area that registers patients. However, we found that only two areas have completed their operations manual as required. Also, when comparing practices in place with applicable policies and procedures within the Institutional Handbook of Operating Procedures, Patient Access Departmental Policies and Procedures, and Hospital and MSRDP Operations Manual we found policies and/or procedures have not been adequately developed for key revenue cycle activities under review such as patient registration, insurance verification, pre-authorization, precertification, medical necessity, scheduling, quality assurance and professional behavior/customer service. Also, although UT System Policy 155 requires key revenue cycle procedures be included within the UTHSCT Hospital and MSRDP Operations Manual for the twenty-eight revenue cycle activities identified, there are only eleven revenue cycle activities where policies or procedures were included within the manuals for proper guidance.

Recommendation #2: The Director of Business Operations should ensure policies or procedures are developed to provide adequate guidance for key revenue cycle operations and these policies and procedures should be added to the Hospital and MSRDP Operations Manual that is located on the UTHSCT Sharepoint site. In addition, policies and procedures need to be made available to the appropriate personnel.

Management's Response: Key revenue cycle policies and procedures will be written and uploaded to the Patient Access Sharepoint and UTHSCT Hospital and MSRDP Operations Manual as required by UT System Policy 155.

Implementation Date: August 31, 2013

Insurance Verification/Pre-authorization/Pre-certification

Overall, Internal Audit believes processes and tools for verifying insurance are adequately deployed to ultimately promote effective billing for inpatient admissions and certain ordered procedures. However, for certain services such as office visits and lab, insurance verification procedures are not performed. Management could not produce any documentation supporting why the decision was made to scope out certain services from the insurance verification requirement, whether a cost vs. benefit approach was taken and who authorized it. Audit believes with the electronic resources that are currently available to all registration personnel it is important for management to re-consider time requirements and the costs vs. benefit of verifying insurance coverage for other services. Insurance verification is important in validating the accuracy of information for claim submission and application of appropriate collection policies based upon the patient's financial classification. Insurance verification on the front-end can reduce re-work by the institution's business office.

Recommendation #3: The Director of Business Operations, Patient Access Manager, PFS Billing Supervisor and the Director of Case Management need to collaborate to evaluate the cost vs. benefit of extending insurance coverage verification to services other than inpatient admissions and certain ordered procedures. Consideration should be given to topics such as the magnitude of accounts in which insurance data initially obtained is inaccurate, costs for re-working the claim during the collections process when inaccurate data is obtained, and whether staff time requirements and costs are reasonable for verifying the insurance during the registration process for certain services.

Management's Response: The Director of Business Operations will collaborate with key management to evaluate the feasibility of extending insurance verification procedures to services where insurance is currently not verified.

Implementation Date: August 31, 2013

Training

Patient Access Management has effectively implemented a training program for patient registration processes that includes basic and refresher training on key topics identified by management or requested by staff members. Although Patient Financial Services has effectively implemented a training program for patient registration processes the program design, training results and decisions concerning training requirements are not well documented. Internal Audit identified the following areas in which the training program needs to be improved:

- The training program is not formally documented and there are no written program requirements to document management's expectations for the patient registration training provided to staff. As a result Audit could not determine the adequacy of the program and whether the training program in place meets management's expectations.
- The process in place to identify and document employees who need to be trained in patient registration procedures and related topics is inadequate. As a result, Audit could not determine who needed to attend certain training sessions and whether attendance was sufficient.
- Although sign-in logs are kept for some training and staff meetings, sign-in logs are not consistently used to document training attendance. As a result, Audit could not determine if employees that needed to be trained were trained.
- Currently, for new employee training sign-in logs are not used to document attendance. Although the Training Specialist indicates that each employee is required to demonstrate competency in registration there is no documentation available to support competencies were achieved.
- Patient Access management indicates that they require Patient Access employees attend at least three refresher registration training sessions annually. However, the method for tracking and monitoring progress is not adequate to ensure that all staff obtain at least the minimum refresher training required during the year.
- Some of the training materials provided to Internal Audit were outdated and need to be revised to reflect the current procedures.
- There is no documentation to support that Business Operations management has reviewed and approved the patient registration training materials and training schedules.

Recommendation #4: The Training Specialist II in collaboration with the Patient Access Manager need to implement processes for adequately documenting patient registration training program requirements, results of training, management oversight of the training program and schedule, and employee completion of required training.

Management's Response: The Training Specialist II in collaboration with the Patient Access Manager and Director of Business Operations will formally document the institution's training program ensuring that it meets management's expectations. A process will be developed for formally identifying and documenting employees who need to be trained and employees that receive training. Sign-in logs will be kept for all live training and Performance Manager will be used to document electronically provided training. Records will be retained to support new hires

met competency requirements. Training materials will be updated as needed. The Patient Access Manager or Director of Business Operations will review and approve training materials and training schedules.

Implementation Date: September 1, 2013

Quality Assurance
Patient Access has processes in place for resolving errors and deficiencies in patient information identified within Pre-registration and Unbilled reports and Meditech and ePremis (claim scrubbing software) edits to get claims submitted. However, the current quality assurance process lacks the following:

- There are no electronic tools for monitoring registration staff performance and no periodic audits are performed to validate if registration staff is consistently and adequately obtaining information needed for reimbursement.
- Currently processes are in place to just make data corrections but there is no process in place for identifying and resolving the root cause of the errors.
- Reports currently in use for resolving deficiencies do not include the date of service or discharge, which are needed to prioritize resolution. Also, there do not appear to be well-defined tracking mechanisms in place to help ensure timely resolution of errors.
- There are no measures in place for tracking and monitoring staff performance and related training activities that directly correspond to the level of errors and re-work required.

Recommendation #5: The Director of Business Operations in collaboration with the Patient Access Manager should:

a) Explore the feasibility of purchasing a patient access automated solution with quality assurance tool features for monitoring registration staff performance to reduce or eliminate re-work in the collections process due to errors made in the registration process. Alternately, management should implement manual processes for performing periodic audits to validate performance quality.
b) In addition to correcting errors and deficiencies identified within the Pre-registration Status Reports, Meditech Unbilled Reports and ePremis Edits Reports, management should implement processes for identifying and resolving the root cause of the errors.
c) Revise reports used in the data corrections processes to include date of service or discharge date to ensure older transactions are prioritized for resolution.
d) Implement processes for tracking and monitoring corrections to ensure these are made timely.
e) Provide supplemental staff training based on errors and deficiencies identified within the error resolution processes.

Management's Response:

a) The Director of Business Operations is currently reviewing an automated solution with an established vendor and will submit a proposal to the CFO by January 15, 2013.

Should the automated solution not be approved by senior management, manual processes will be implemented for performing periodic audits to validate performance quality.

b) The Patient Access Manager will implement processes for identifying and resolving the root cause of errors and deficiencies identified within the Pre-Registration Status, Unbilled and Edits reports.
c) The Patient Access Manager will collaborate with the Information Technology Department to revise reports to bring in the key fields of discharge or service date.
d) The Patient Access Manager will implement processes for tracking and monitoring patient account corrections made due to errors reported on the Pre-Registration Status, Unbilled and Edits reports to ensure these are resolved timely.
e) Staff training will be provided by the Training Specialist based upon deficiencies identified within the error resolution processes using the Pre-Registration Status, Unbilled and Edits reports.

Implementation Date:

a) Explore Feasibility of Automated Solution: March 31, 2013; Implement Automated Solution: January 1, 2014 OR Implement Manual Audit Processes: September 1, 2013
b) – e): June 30, 2013

Patient Complaints

UTHSCT has a process in place for adequately tracking and resolving patient complaints relative to the front-end revenue cycle process that are made directly to the Office of Healthcare Quality. Resolution of billing issues for these complaints is satisfactorily documented within the patient information system. However, for non-care related patient complaints made directly to Patient Access staff and supervisors there is no method in place for documenting the receipt and resolution of these complaints. Lack of documentation of patient complaint resolution increases the risk that complaints may not be properly addressed or resolved. It also increases the risk for unnecessary costs for staff time spent reviewing a subsequent complaint by the same patient that has been previously reviewed but not documented. The ultimate effect may be increased patient dissatisfaction and failure to identify process weaknesses.

Recommendation #6: The Patient Access Manager should develop a process for identifying which patient complaints need to be tracked by the department and a tracking mechanism should be implemented for tracking the receipt and resolution of patient complaints received by the department.

Management's Response: The Patient Access Manager's plan of action will be to develop a canned text in PBR/BAR to track patient complaints and for follow-up for patient satisfaction.

Implementation Date: September 1, 2013

Conclusion

Overall, patient registration processes and systems appear to be adequate to support timely, accurate and efficient billing. However, we believe implementation of the recommendations noted above will improve processes and controls.

Kris I. Kavasch, Director of Internal Audit

Summary of Significant Findings

According to The University of Texas System, a significant finding is one that may be material to the operation, financial reporting, or legal compliance of the university if corrective action has not been fully implemented. This would include an internal control weakness that does not reduce the risk of irregularity, illegal act, error, inefficiency, waste, ineffectiveness, or conflict of interest to a reasonably low level.

In view of the above requirements, the Patient Access Audit – FY 2013 had no significant findings.