Office of Internal Audit

UT Southwestern Medical Center

The University of Texas Southwestern Medical Center
Managed Care Adjustments Audit
Internal Audit Report 16:06

October 12, 2016

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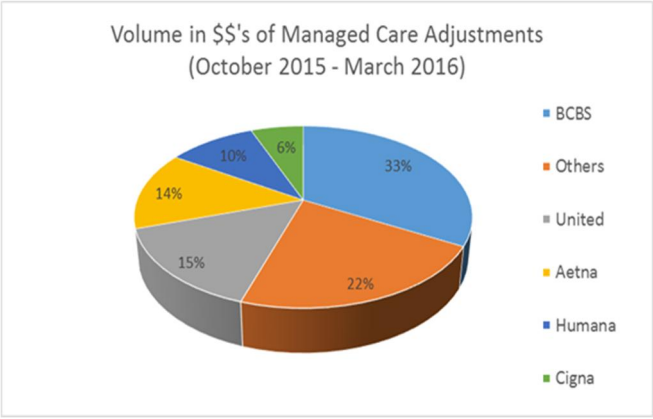
Executive Summary

Background

The University of Texas Southwestern Medical Center (UT Southwestern) has executed contracts with thirty Managed Care Organizations (MCO) for the reimbursement of covered inpatient and professional services provided to their plan participants. The responsibility for the negotiation of these contracts and the related fee schedules and reimbursement terms lies with the MSRDP Business Operation Administration team, with oversight by the Managed Care Contracting Committee. Once agreed upon terms are finalized, they are loaded to the Epic system and used to calculate the expected reimbursements for billed services. The difference between the standard amounts billed for services and the amounts allowed for reimbursement in accordance with the managed care contracts are reflected in the Epic billing system as the managed care adjustment.

The illustration here shows the overall percentage of managed care adjustments posted for the largest five MCOs during the audit period. Please refer to Appendix B for separate illustration of Professional (PB) and Hospital (HB) percentages and totals.



When hospital charges are billed, the managed care adjustments are calculated within Epic and posted to the patient's account at the time the bill is sent to the MCO. When payments and explanation of benefits (EOB) are received for the account and posted, if there is a variance between what was expected as payment and what was received the account is moved to a variance work queue for analysis and follow up. There are six Variance Account Specialists and one Supervisor reporting to the Collections Operations Manager within Billing Operations, responsible for thirteen variance work queues. At the time of the audit fieldwork, these variance work queues held 3478 accounts with balances totaling over $9.3 million dollars.

For professional charges, the managed care adjustment is posted to the patient's account in accordance with the payment and EOB received from the MCO. UT Southwestern Billing Operations utilizes a third party, Experian, to review professional billings to identify contract underpayments and manage billing appeals with the MCOs on UT Southwestern's behalf. Experian receives a fee for these services equal to 35% of appeal recoveries. From January 2016 through June 2016, Experian was paid $95,000 for $270,000 of professional billing recoveries.

Executive Summary

Objectives and Scope

This audit was risk based and scheduled as a part of our Fiscal Year 2016 Audit Plan. The audit focused primarily on the process to apply managed care adjustments to patient accounts. The audit scope period was October 2015 through August 2016. Audit procedures included: interviews with the MSRDP Contract Administration team and Billing Operations collection teams; review of policies and procedures and other documentation; analysis and testing of managed care adjustments posted to patient accounts; and review and analysis of managed care contract fee schedule updates, hospital billing variance work queues, and professional billing appeal services provided by Experian.

The overall objectives of the audit were to assess the adequacy and effectiveness of internal controls over managed care adjustments at UT Southwestern. Specifically, to assess and provide reasonable assurance for:

- Timely and accurate managed care contract adjustments to patient accounts
- Timely analysis and collection procedures on collections outside of contract billed amounts
- Authorized and accurate adjustments to patient accounts
- Effective oversight and monitoring of operations

We conducted our examination according to guidelines set forth by the Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing.

Conclusion

Overall, procedures and controls can be enhanced to improve the oversight and monitoring of managed care adjustments. Specifically, quality assurance audits of manually posted hospital managed care adjustments should be resumed to ensure their accuracy. Additionally, the root cause of hospital managed care billing variances should be enhanced to better quantify and monitor potential contracting or other issues.

Specific strengths identified during the audit include:

- Managed Care contracts are negotiated under proper authority based on supported analysis.
- Managed Care fee schedules are tested in a secure testing environment prior to being moved to production.
- Procedures are in place to analyze all variances between expected and actual managed care payments.

The table below summarizes the observations and the respective disposition of these observations within the UT Southwestern internal audit risk definition and classification process. See Appendix A for Risk Rating Classifications and Definitions.

Priority (0)	High (1)	Medium (4)	Low (1)	Total (6)

Executive Summary

There were no priority issues identified in the audit. Key improvement opportunities risk-ranked as high and medium are summarized below.

- **Reestablish hospital managed care adjustments quality assurance audit procedures -** Random sample review of manually posted hospital managed care adjustments (935 adjustment codes) have not been performed since turnover in the QA analyst position, increasing the risk of inaccurate managed care adjustments.

- **Identify root cause for payment variances for hospital billings -** Reason codes for payment variance are not identified in order to provide analysis and insight to management of trending contract or coding issues.

- **Improve monitoring of invoicing of Professional billing recovery charges -** There is no accountability for monitoring the accuracy or validity of the invoiced charges billed by Experian, and sample testing identified overcharges.

- **Improve change control process for updating hospital fee schedules in Epic -** Responsibilities for testing and approving hospital fee schedule updates to Epic have not been appropriately segregated.

- **Ensure appropriate system access is assigned to third party vendor employees –** Experian employees had network and system access that was inconsistent with their roles and responsibilities.

Management has implemented or is in the process of implementing corrective action plans. Management responses are presented in the Detailed Observations and Action Plans Matrix section of this report.

We would like to thank management of the MSRDP Contract Administration Department and Billing Operations for their assistance and cooperation during this review.

Sincerely,

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Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: High **1. Reestablish Hospital Managed Care Adjustments Quality Assurance (QA) Audit Procedures** Procedures previously in place to perform random sample review of manually posted hospital managed care adjustments (935 adjustment codes) have not been performed for six months due to turnover in the QA Analyst position. Because there are no system controls requiring secondary authority of manual managed care adjustments of any amount, not having the QA process in place to monitor the appropriateness of these adjustments increases risk of inaccurate managed care adjustments.	1. Reestablish managed care adjustment QA audit procedures which utilize a statistical risk based sampling methodology. 2. Provide timely reporting to management of the results.	**Management Action Plans:** 1. Revenue Cycle Analytics will design statistical risk based QA audit procedures for review of managed care adjustments. 2. Revenue Cycle Analytics is activity recruiting to fill the vacant QA Analyst position. Once hired, the analyst will implement the QA audit procedures and provide reporting on the results to Hospital Billing Operations management for the monitoring and oversight of managed care adjustments. **Action Plan Owners:** Manager, Revenue Cycle Analytics, Patient Financial Services **Target Completion Dates:** 1. November 30, 2016 2. February 28, 2017

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Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium **2. Identify Root Cause for Payment Variances for Hospital Billings** Reason codes for the root cause of individual hospital payment variances are not identified in order to provide analysis and insight to management of trending contract or coding issues. Due to the large volume of variances in work queues, opportunities to better identify and address common issues should be pursued. The use of claim level reason codes will provide more efficient identification and correction of the root causes of variances. Currently, there is limited reporting available to define why accounts are flagged within the hospital billing variance work queues. Contract issues must be identified and tracked manually by collection agents and recorded to manual spreadsheets for escalation to management. Hospital finance personnel also review monthly variance information as a part of the close process. Efforts are underway to revise the work queue platform to establish a more efficient flow of accounts to one work queue at a time, where feasible. This project will be a comprehensive overhaul of the work queue methodology, and improvements to variance reason codes could be considered as part of the project. However, the functionality for these codes does not currently exist in Epic.	Coordinate with HSIR Revenue Cycle and Business Systems to evaluate system enhancements that would enable reason codes for account variances. Key steps of this project will include. • Development of activity codes that define the reason a hospital account has been paid outside the expected full contracted amount. • Performing a feasibility study to evaluate options for incorporating the action codes into the Epic functionality. • Establishing a plan for implementation based on the feasibility study results; either updating of the Epic functionality or acceptable alternative. • Implementation of the established plan. • Development of monthly reporting to support the trending and tracking of activity codes for variance root causes. • Establishing procedures to analyze variance root causes and develop action plans to resolve.	**Management Action Plans:** 1. Hospital Billing Operations will develop activity codes to categorize account variances by reason. 2. Health Systems Information Resources (HSIR) will perform a feasibility study on the options to incorporate the activity codes into the Epic functionality. 3. HSIR will establish a plan for implementation of the decided course of action. 4. HSIR will implement the established plan. 5. After implementation, Hospital Billing Operations will develop monthly reports to track and analyze variance work queue activity by root causes. 6. Procedures will also be established for Hospital Billing Operations and partners to take action on Hospital billing variance root causes identified from the monthly analysis. **Action Plan Owners:** Director, Revenue Cycle and Business Systems Operations Manager, Collections – Patient Financial Services

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Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
		Target Completion Dates: 1. October 31, 2016 2. December 31, 2016 3. December 31, 2016 4. February 28, 2017 5. March 31, 2017 6. March 31, 2017

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium **3. Improve Change Control Process for Updating Hospital Fee Schedules in Epic** Responsibilities for testing and approving hospital fee schedule updates to Epic have not been appropriately segregated. New hospital managed care contract fee schedules, or revisions, are provided by MSRDP Business Operations to an analyst within Hospital Billing Operations who is solely responsibility for building, testing and authorizing Information Resources (IR) to upload the new contract terms to production in Epic. Concerns with the current process include the following: • The analyst reviews each revised contract term for accuracy in the test environment, however there is no independent validation of this testing, nor review of the accuracy of the final contract changes after they have been loaded to the Epic production environment. • The analyst position assigned to perform the hospital fee schedule updates is also responsible for performing QA reviews for billing accuracy; two responsibilities that inherently conflict.	Management from MSRDP Business Operations and Information Resources should collaborate to develop a revised process to address the segregation of duties concerns for changes to hospital managed care fee schedules. The revised process should segregate the following responsibilities: • Contract term interpretation • User authorization of the change • Epic build • Validation testing	**Management Action Plans:** 1. A revised process that addresses the segregation of duties concerns in this report will be developed and approved by a cross functional team within 60 days. 2. Training for responsible parties will be obtained in accordance with the requirements of the revised process. 3. The revised process will be fully implemented. **Action Plan Owners:** Associate Vice President, MSRDP Business Operation Administration Director, Revenue Cycle and Business Systems Associate Vice President, Revenue Cycle Operations

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Appropriate change control procedures require segregation of the request, authorization and validation testing of fee schedule system updates. A survey of UT System medical institutions identified best practices that included a collaboration between IT and the managed care analytics group to maintain fee schedules.		**Target Completion Dates:** 1. December 31, 2016 2. January 31, 2016 3. February 28, 2016

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium **4. Improve monitoring of invoicing of Professional billing recovery charges** Procedures are not in place for monitoring the accuracy or validity of the invoiced charges billed by Experian. Responsibility for the Experian vendor relationship has been held within the MSRDP Business Operation Administration area, with an expectation that Department Billing Operations would provide monitoring of the accuracy and validity of the charges invoiced. While Experian monthly reports are shared in a public drive, monitoring of the invoice charges was not performed. From January 2016 through June 2016, Experian was paid $95,000 for $270,000 of professional billing recoveries. The Experian contract language indicates that the 35% contingency fee is governed by successful appeal and collection efforts of underpaid accounts. In a sample of 75 Experian charges, fourteen accounts had the full contingency fee charged on recoveries that had not been fully collected. Based on actual collections of appealed accounts for the sample, the effective fee charged by Experian was 38.1%. The Experian contract is currently under renegotiation and responsibility for the new contract and vendor relationship will be transferred to Billing Operations.	1. As part of the execution of the new contract with either Experian or another selected vendor, reemphasize the contract terms stating contingency fees will be calculated against actual collections of appealed underpayments. 2. Establish monitoring procedures within Billing Operations for the monthly vendor invoices to ensure that charges are based on valid and collected recoveries.	**Management Action Plans:** 1. Profession Billing Operations will ensure that negotiations of the contract with the selected vendor will include contingency fee calculations that are based on actual collections of appealed underpayments. 2. Procedures will be developed within Professional Billing Operations for the timely review of the monthly vendor invoices for valid and accurate charges. **Action Plan Owners:** Associate Vice President, Revenue Cycle Operations **Target Completion Dates:** 1. January 31, 2017 2. February 28, 2017

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium **5. Ensure appropriate system access is assigned to third party vendor employees** There are eleven Experian employees with vendor designated access to the network and Epic. All Epic security access for Experian users should be view only. Review of the assigned system access security for these individuals identified the following: • Three Experian employees have network access that does not expire. Per policy, vendor network access is assigned in annual increments, which must be renewed each year by UT Southwestern. • One Experian employee has access that allows them to modify data, instead of read only access. • One Experian employee has active network access, but has inactive Epic access.	1. Revise network and Epic system access security for the current Experian employees that is appropriate for outside vendors. 2. Upon transfer of the vendor relationship and contract to Billing Operations, implement procedures to review and confirm the system access for the selected vendor's employees on a monthly basis.	**Management Action Plans:** 1. MSRDP Business Operations will review Epic system access currently assigned to Experian employees and request any necessary updates for security that is not appropriate for outside vendors. 2. The oversight of the contract will be transferred from MSRDP Business Operations to Professional Billing Operations, at which time procedures will be implemented in Professional Billing Operations to review the status of the vendor employees and their assigned system access on a monthly basis. **Action Plan Owners:** Director Physician and Specialty Contracting, MSRDP Business Operation Administration Associate Vice President, Revenue Cycle Operations **Target Completion Dates:** 1. November 30, 2016 2. December 1, 2016

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Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Low ● **6. Finalize contract with vendor providing third party billing appeal services for professional charges** The contract with Experian, the third party vendor who provides professional billing appeal services on behalf of UT Southwestern, has expired and is operating under a temporary six-month addendum that will expire in October 2016. Contract renewal with Experian has been delayed due to requirement to perform an RFP. Because the vendor has access to the UT Southwestern Epic system and patient information to perform these services, it is important that there be a formal and current contract that includes a Business Associate Agreement for HIPAA compliance.	1. Complete the RFP for the professional billing appeal services currently provided by Experian. 2. Finalize the contract and Business Associate Agreement with the chosen vendor.	**Management Action Plans:** 1. Billing Operations management will complete the RFP and execute the contract renewal with the vendor before the expiration of the current contract extension. 2. The contract with the vendor will include an appropriate Business Associate Agreement. **Action Plan Owners:** Associate Vice President, Revenue Cycle Operations **Target Completion Dates:** 1. January 31, 2017 2. January 31, 2017

Appendix A: Risk Classifications and Definitions

As you review each observation within the Detailed Observations and Action Plans Matrix of this report, please note that we have included a color-coded depiction as to the perceived degree of risk represented by each of the observations identified during our review. The following chart is intended to provide information with respect to the applicable definitions and terms utilized as part of our risk ranking process:

	Degree of Risk and Priority of Action	
Risk Definition - The degree of risk that exists based upon the identified deficiency combined with the subsequent priority of action to be undertaken by management.	**Priority**	An issue identified by internal audit that, if not addressed immediately, has a high probability to directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole.
	High	A finding identified by internal audit that is considered to have a high probability of adverse effects to the UT institution either as a whole or to a significant college/school/unit level. As such, immediate action is required by management in order to address the noted concern and reduce risks to the organization.
	Medium	A finding identified by internal audit that is considered to have a medium probability of adverse effects to the UT institution either as a whole or to a college/ school/unit level. As such, action is needed by management in order to address the noted concern and reduce risk to a more desirable level.
	Low	A finding identified by internal audit that is considered to have minimal probability of adverse effects to the UT institution either as a whole or to a college/ school/unit level. As such, action should be taken by management to address the noted concern and reduce risks to the organization.

It is important to note that considerable professional judgment is required in determining the overall ratings presented on the preceding pages of this report. Accordingly, others could evaluate the results differently and draw different conclusions.

It is also important to note that this report provides management with information about the condition of risks and internal controls at one point in time. Future changes in environmental factors and actions by personnel may significantly and adversely impact these risks and controls in ways that this report did not and cannot anticipate.

Appendix B: Managed Care Adjustments Statistics

The following charts provide a summary of the managed care adjustment volumes in total dollars for the noted time period. The statistics represent the percentage of total Professional managed care adjustments and Hospital managed care adjustments attributable to the five largest Managed Care Organizations (Blue Cross and Blue Shield, United Health Care, Aetna, Cigna, and Humana) and all others combined. These percentages are driven by both the volume of services provided to patients from each MCO, and negotiated fees schedules applicable to each MCO.