Office of Internal Audit

UT Southwestern Medical Center

Revenue Cycle Patient Registration and Authorization Audit

Internal Audit Report 17:06

September 15, 2017

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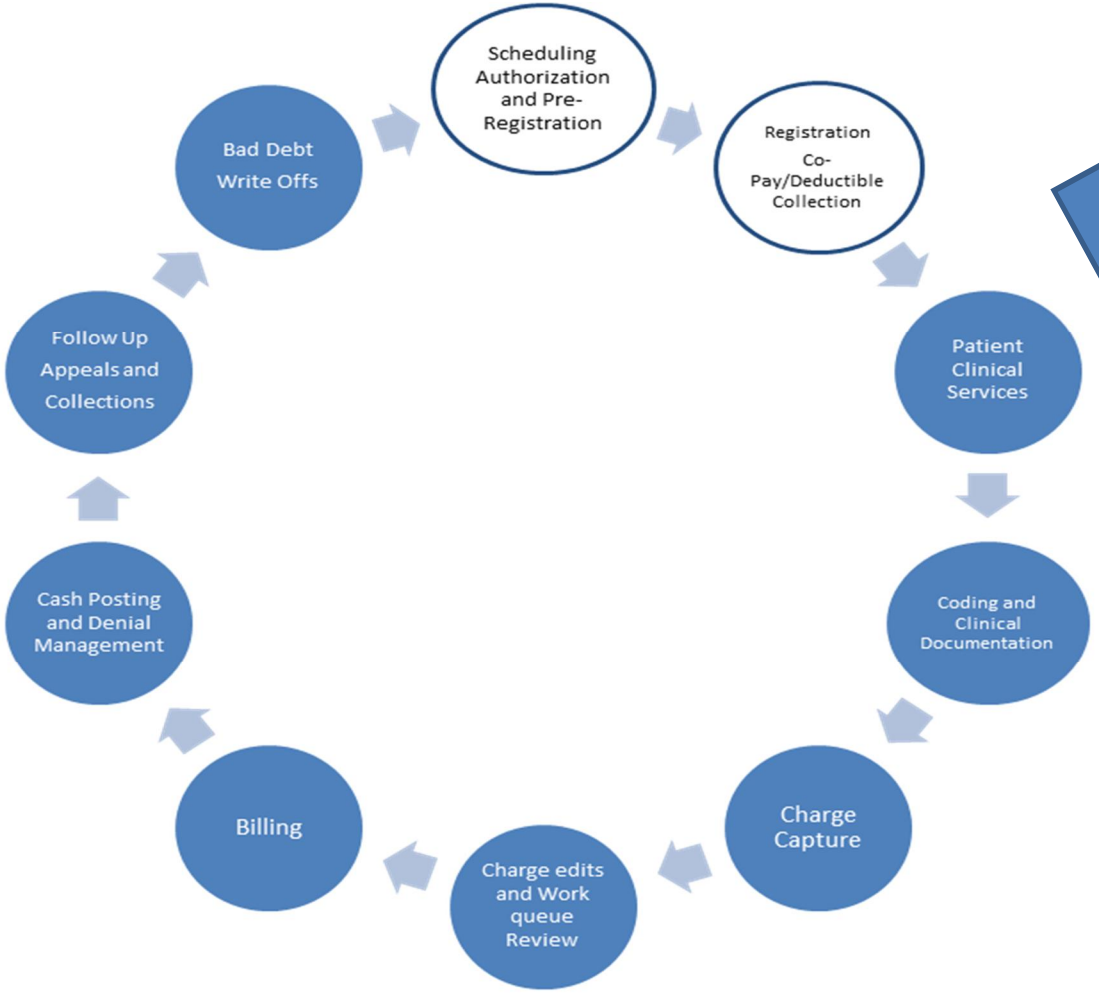
Executive Summary

Background

UT Southwestern Medical Center (UT Southwestern) provides patient services at William P. Clements Jr. University Hospital and Zale Lipshy University Hospital, as well as the hospital based clinics and Ambulatory outpatient clinics across campus and at off site locations. Hospital admissions totaled 280,000 and outpatient appointments totaled 904,000 through 11 months ended July 31, 2017.



The Revenue Cycle process starts with patient registration and authorization

Executive Summary

The registration process begins with a patient request for appointment, either by telephone, online form or for existing patients, MyChart, which is UT Southwestern's secure, online health management tool to make appointments and easily communicate with physicians and clinic personnel regarding routine questions about health care. Outpatient appointments are scheduled centrally or directly with individual clinics for those that are not a part of central registration. Hospital appointments are scheduled by hospital-based clinic personnel. Hospital-based surgery appointments are scheduled by clinic personnel directly with the operating room scheduling team.

Once scheduled, central registration or individual clinic personnel will begin the insurance and benefits verification. This is typically performed 14 days prior to the appointment and no later than the patient's arrival at the appointment. Procedures identified as requiring prior insurance authorizations are submitted to each insurance provider for approval based on physician orders prior to performing the procedures. Providers enter the procedure codes in Epic and clinic or central registration staff will obtain insurance authorizations based on the codes provided. Patient amounts due, based on insurance coverage, are also calculated and communicated to the patient prior to the appointment. During admissions, patients provide their photo identification, insurance card(s) and payments as applicable.

Standard procedures for this process were developed by the Revenue Cycle team and various areas are responsible for executing the process based on their reporting structure, including Revenue Cycle, hospital leadership, clinic leadership and department leadership. All of these areas coordinate with the other Revenue Cycle functions, as needed, to monitor denials activity, as this is the monitoring activity to identify any weaknesses in the Revenue Cycle process.

The Epic patient accounting system facilitates the patient registration and authorization process.

Objectives and Scope

This audit was risk-based and scheduled as a part of our Fiscal Year 2017 Audit Plan. The audit focused on the standard operating processes, related monitoring procedures and a detailed review of operations at a sample of hospital-based and ambulatory clinics. The audit also focused on monitoring of denials related to authorizations and eligibility, evaluation of insurance verification and authorization processes and retention of patient documents at check in. The audit scope period was September 2016 through May 2017.

Audit procedures included: interviews with the central Ambulatory, Hospital, and specific decentralized clinic team members and leaders, walkthroughs, review of policies and procedures and other documentation; and analysis and testing of denials types, authorizations, related work queues, check-in supporting documents and payments.

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Overall objectives for the review included determining the adequacy and effectiveness of process, oversight, and monitoring controls in place at the hospitals, hospital-based clinics, Ambulatory clinics and School of Health Profession's clinics to ensure:

- Accurate patient registration and financial status (payor type, charity care, self-pay, secondary payor, etc.)
- Complete insurance authorizations
- Patient notification of amounts to be collected
- Completed patient forms signed and retained
- Denials based on insurance verification and/or authorization are reviewed and followed up timely
- Quality assurance and monitoring of registration and authorizations is performed routinely

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, the procedures for patient registration are well designed, however, there are opportunities to increase oversight due to the largely decentralized function with varied accountability and limited oversight and monitoring by the hospital and ambulatory central functions. Specifically, during pre-registration, when incomplete insurance authorizations are obtained, flags are not in place to ensure procedures charged are the same as procedures authorized prior to final billing. Updating automated flags to identify non-covered procedures will ensure patients are notified of their out of pocket responsibility in advance of service.

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

There were no Priority risk issues identified in the audit. Key improvement opportunities risk-ranked as Medium are summarized below.

Priority (0)	High (0)	Medium (2)	Low (1)	Total (3)

- **#1 Improve the Insurance Authorization Process** – Automated or manual flags are not in place to ensure additions and/or changes to procedures are communicated to the insurance company prior to final billing.

- **#2 Enhance Process for Notifying Patients of Non-Covered Amounts Prior to Service –** Automated flags to identify non-covered procedures should be updated to minimize the loss of revenue if the patient is not notified in advance of the service.

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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 (Matrix) section of this report.

We would like to thank the various department and Revenue Cycle teams for their assistance and cooperation during this review.

Sincerely,

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UT Southwestern Medical Center

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium **1. Improve the Insurance Authorization Process** Incomplete insurance authorizations are resulting in denials from payors. Automated or manual flags are not in place to ensure additions and/or changes to procedures are communicated to the insurance company prior to final billing. Additional factors identified: · Authorization information is not consistently documented in the authorization/referral Epic fields. · Documentation from the insurance companies on approved codes is not captured in the authorization/referral records in Epic. Physicians enter service procedures in Epic and clinic personnel ensure authorizations are received in advance of services performed. During the patient's visit, physicians may change or add procedure codes that were not included in the initial authorization. If the insurance company is not notified of these updates in advance of billing, these changes will be denied. Communication between physicians and clinic personnel is needed to convey updates so authorizations are obtained prior to billing. Denials related to authorizations are the primary driver of denial activity within the Institution.	1. Provide additional training to registration personnel, providers and clinical staff on standard processes to obtain complete authorizations and document in the Epic authorization/certification module. 2. Update the insurance authorization process to include automated or manual flags to ensure additions and/or changes to procedures are communicated by the physician to billing personnel and the insurance company prior to final billing in order to minimize denials related to insurance authorizations.	**1. Management Action Plans:** There is currently a Revenue Cycle workgroup project team working on an authorization project. Their initiatives include: Evaluate accuracy of scheduled procedures to determine our ability to get correct procedures documented on initial review. Update process for evaluating authorized procedures against performed procedures needs to be developed for the authorization referral team to communicate with insurance companies. Training for registration personnel on documentation from insurance plans to be captured in Epic and updates in the authorization/certification module will be completed by 12/31/17 and then will continue as an ongoing option due to access and staff availability. Education for providers/nursing staff to ensure appropriate codes are entered into Epic will be completed by 4/30/18. **Action Plan Owners:** Associate Vice President Revenue Cycle Operations Director Front End Medical/Surgical Billing, MSRDP Billing Operations Administration

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Specifically related to authorizations: · Hospital and hospital based clinics denials were $21million from September 2016 through May 2017. · Denials for selected Ambulatory clinics were $212,000 from September 2016 through May 2017. Incomplete insurance authorizations that are not updated prior to final account billing will result in loss of revenue and cash flow to UT Southwestern.		**Target Completion Dates:** December 31, 2017 - Training for registration personnel April 30, 2018 – Training for providers and nursing staff **2. Management Action Plans:** Workflow redesign will be developed via a workgroup to include process, technology and training updates. Final process updates and training will be communicated by 8/31/18. **Action Plan Owners:** Associate Vice President Revenue Cycle Operations Director Front End Medical/Surgical Billing, MSRDP Billing Operations Administration **Target Completion Dates:** August 31, 2018

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium **2. Enhance Process for Notifying Patients of Non-Covered Amounts Prior to Service** The list of non-covered procedure codes in Epic is not complete, resulting in recurring denials. The listing needs to be updated to include additional frequently occurring procedures. Preventable non-covered procedure denials totaled $13 million for September 2016 through May 2017. Denials related to non-covered procedures result in loss of revenue if the patient is not notified in advance of the service and, if applicable, an Advanced Beneficiary Notice (ABN) or Notice of Non-Covered Waiver is not completed. In addition, automated triggers are not in place in Epic to notify the patient of non-covered procedures provided by the Psychiatry Private Practice clinic. Denials for this clinic totaled $140,000 (.01% of total charges) for September 2016 – May 2017. Maintaining a complete non-covered procedure list will ensure system triggers are in place to alert admissions personnel to obtain a signed patient authorization form and reduce the risk of revenue loss.	1. Update the non-covered procedures listing within EPIC to include procedures recurring in denials reporting. 2. Develop monitoring of denial reporting to ensure the listing of non-covered procedure codes is routinely updated. 3. Develop non-covered procedure triggers for use in the Psychiatry Private Practice clinic.	**Management Action Plans:** 1. Develop project plan to include: a. Coordinate and obtain approval from the Medical Necessity/Authorization committee to add additional non-covered flags in EPIC. This committee addresses both Hospital and Ambulatory edits. b. Review monthly denials to identify additional opportunities to add CPT codes to EPIC as well as identify training opportunities for registration personnel who routinely dismiss non-covered flags. c. Update EPIC flags for non-covered CPT codes for Psychiatry. **Action Plan Owners:** Associate Vice President Revenue Cycle Operations Director, Ambulatory Business Services **Target Completion Dates:** November 30, 2017 – Develop project plan with milestones

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Low **3. Improve Insurance Eligibility Verification Procedures** Insurance eligibility is not consistently obtained prior to patients check-in to confirm insurance coverage. Denials for selected ambulatory clinics related to insurance verification totaled $150,000 for "*patient not insured*" and "*expenses after coverage terminated*". Additionally, a sample of patients that arrived at the selected clinics noted insurance cards were not always scanned and stored in the patient's EPIC account record. A field within EPIC is utilized to remind registration personnel to obtain copies of patient identification and insurance card, however monitoring is not in place to ensure this information is consistently obtained. As a result, validation of coverage and benefits may be incomplete. The lack of monitoring controls for ensuring employees are obtaining key documents from patients increases the risk of insurance eligibility denials and risk of patient account inaccuracies.	1. Develop monitoring procedures to confirm insurance eligibility prior to performing services. 2. Ensure registration personnel are consistently obtaining copies of patient identification and insurance card. 3. Report on results of monitoring monthly to determine if additional system flags are needed or if employee education is required.	**Management Action Plans:** 1. Utilizing denial information, identify clinics with recurring denials related to insurance eligibility and work with clinic leaders to improve the eligibility process. 2. In coordination with EPIC IR team, develop reporting to identify appointments where no insurance card or patient identification is uploaded. 3. Based on reporting developed in #2, work with clinic leaders to develop action plans to ensure insurance cards and patient identification are obtained. **Action Plan Owner:** Director, Ambulatory Business Services **Target Completion Dates:** November 30, 2017, with ongoing monitoring of activities

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 the 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.

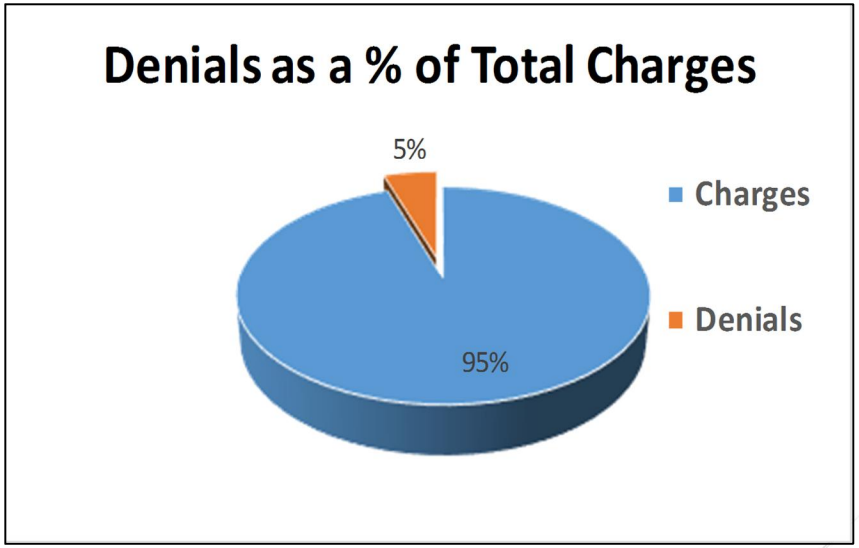
It is important to note that considerable professional judgment is required in determining the overall ratings presented on the preceding pages of this report. Accordingly, others could evaluate the results differently and draw different conclusions.

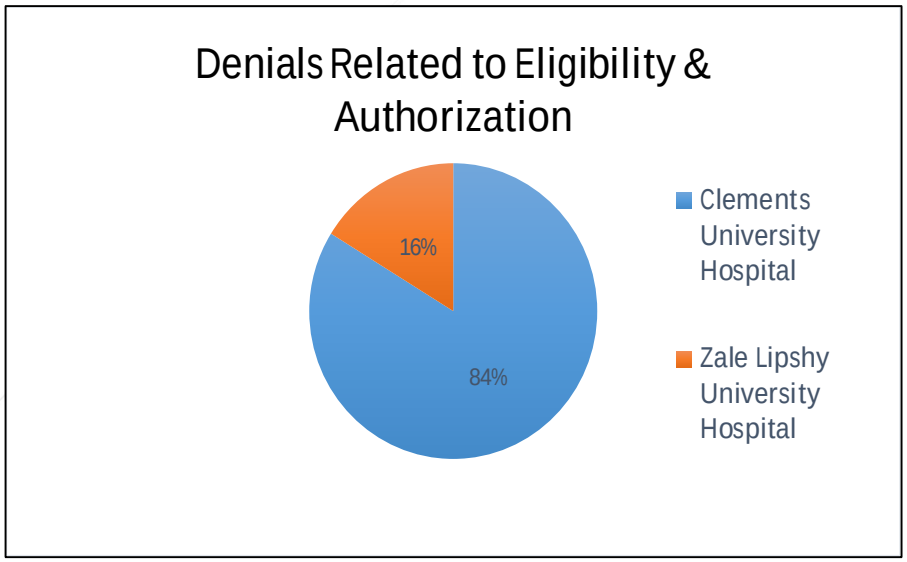
It is also important to note that this report provides management with information about the condition of risks and internal controls at one point in time. Future changes in environmental factors and actions by personnel may significantly and adversely impact these risks and controls in ways that this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

Appendix B – Denials by Functional Area

Overall denial rate for University Hospitals is 5%, eligibility and authorization related denials are 47% of all denial types.

The charts below illustrate denials as a percentage of total charges as well as eligibility and authorization denial types by hospital.





Appendix B – Denials by Functional Area

The overall denial rate for ambulatory clinics is 3%, which is in line with industry standards. The graph below illustrates Ambulatory charge denials from September 2016 through May 2017 for selected clinics that contributed to total denials for eligibility and authorization related reason types.