

UTSouthwestern
Medical Center™

Office of Institutional Compliance
and Audit Services

Denials Management Audit

Internal Audit Report 26-AS-1126

April 20, 2026



Executive Summary

Denials Management poses considerable financial and operational risks for healthcare providers, including academic centers like UT Southwestern. Industry analyses indicate that a meaningful portion of healthcare claims experience denials or rejections during the revenue cycle, resulting in material revenue risk. While denial rates vary widely by payer mix and service complexity, recent benchmarking shows that denial-related revenue leakage continues to increase across the industry. High-performing organizations often target total denials at or below approximately 3% of revenue, with minimal denial-related write-offs. However, recent data show many providers exceed these levels due to increasing payer complexity, reinforcing the importance of strong denial prevention and management controls.

A robust denials management program helps address root causes, improve department coordination, and enhance controls over registration, authorization, coding, and billing. Ineffective practices, however, can lead to lost revenue, delayed payer follow-up, and inconsistent documentation. At UT Southwestern, separate workflows for hospital and professional billing, along with shared responsibility for certain denials, increase the risk of avoidable losses due to process gaps.

Given the financial impact and complexity across departments, an audit was indicated to assess current denial prevention and management practices at UT Southwestern. The audit aimed to determine if UT Southwestern's framework effectively prevents denial-related revenue loss while ensuring compliance and operational efficiency.

Engagement Results

The Office of Institutional Compliance & Audit Services (OICAS) conducted an internal audit of denials management within both HB and PB, with additional focus on Radiation Oncology and Emergency Department (ED) denials for the period of 12/01/2024 to 11/30/2025 (based on date of service). The audit team identified several strengths within these processes, including a comprehensive Revenue Cycle Operations Standard Operating Procedure (SOP) Library, consistent completion of quality assurance (QA) audits for all Patient Financial Services (PFS) representatives, and detailed PB Clinical Denials issue and resolution tracker.

Revenue Cycle Operations began using Epic Generative AI Suite for drafting outpatient authorization and medical necessity appeal letters in May 2025. The AI scope expanded to cover inpatient technical and clinical denials in December 2025, and PB technical authorization denials in January 2026, though Cancer Center is not yet included. Cofactor, implemented in January 2026, uses AI to tailor appeals letters with payer policies. These AI tools have boosted efficiency, productivity, and denial overturn rates, supporting greater net revenue recovery.

However, the overall engagement results indicate weaknesses across denial review and reconciliation processes and upstream workflow activities based on findings related to appeal and reconsideration submission, root cause assignment, write-off adjustments, Radiation

Oncology prior authorization, and ED insurance verification. These issues may affect operational effectiveness, impact the accuracy of reporting within Epic, reduce the likelihood of complete and timely payer reimbursement, and warrant corrective actions to strengthen internal controls and mitigate risk to enable denial prevention and recovery efforts.

A summary of observations is outlined below:

AREA	OPPORTUNITIES	RISK RATING
Denial Review & Reconciliation	<ul style="list-style-type: none"> • Appeal & Reconsideration Submission • Root Cause Assignment • Write-Off Adjustments 	MEDIUM
Upstream Workflow Impacts	<ul style="list-style-type: none"> • Radiation Oncology Prior Authorization • Insurance Verification 	MEDIUM

Further details are outlined in the Detailed Observations section. Less significant issues and process improvement opportunities were communicated to management.

Management Response Summary

Management agrees with the observations and recommendations and has developed action plans to be implemented on or before January 31, 2027.

Appendix A outlines the objectives, scope, methodology, stakeholder list, and audit team for the engagement.

Appendix B outlines the Risk Rating Classifications and Definitions.

The courtesy and cooperation extended by the personnel in Revenue Cycle Operations, Patient Financial Services and the Department of Radiation Oncology are appreciated.

Natalie A Ramello

Natalie A. Ramello, JD, CIA, CHC, CHPC, CHRC, CHIAP
Vice President, Chief Compliance and Audit Officer
Office of Institutional Compliance & Audit Services
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DETAILED OBSERVATIONS

1. Denial Review & Reconciliation

Denials are not consistently reviewed and reconciled accurately, and/or completely in accordance with standard operating procedures (SOPs) and management expectations, which may limit opportunities for revenue recovery. Gaps in appeal and reconsideration follow-up, inconsistent root cause assignment, and inaccurate write-off adjustment codes reduce the effectiveness of resolution efforts and reporting accuracy. This can increase operational rework and limit management’s ability to identify trends and implement targeted continuous improvement and corrective actions.

MEDIUM

1.1 Appeal & Reconsideration Submission	Recommendations	Management Action Plan
<p>Revenue Cycle leadership noted authorization-related denials due to internal operational inefficiencies, such as lack of attempting/obtaining prior authorization, are not always appealed due to the perceived likelihood to overturn. This process is outlined within the <i>No Authorization, No Referral SOP</i>. Some payers allow retro-authorization within a defined timeframe if initiated, and contract requirements are met; however, there is not a defined process to proactively identify qualified accounts.</p> <p>Testing was performed to evaluate the appeal and reconciliation efforts performed for initial denials and noted that all levels of available appeal and/or reconsideration were not consistently attempted, specifically:</p> <ul style="list-style-type: none"> 7 of 25 (28%) HB accounts did not submit an appeal and/or reconsideration request to attempt to 	<p>Revenue Cycle Operations should consider the following:</p> <ul style="list-style-type: none"> Review all testing exceptions identified with insufficient follow-up activities completed and conduct meetings with the impacted staff to provide education/training of management expectations. Identify accounts from sample testing that are within timely appeal timeframes and have the opportunity to overturn the denial and assign accounts to PFS or appeal and/or reconsideration submission. Expand the work effort pending identified trends (e.g., specific payer and/or procedure denials). Evaluate <i>No Authorization, No Referral SOP</i> to identify and update guidance to attempt first level of appeal utilizing AI appeal functionality within Epic for 	<p>Action Plan Owners: Scott Smith Wathen Strong</p> <p>Action Plan Executive: Kelly Kloeckler</p> <p>Due Date: 6/30/2026</p> <p>Management will:</p> <ul style="list-style-type: none"> Evaluate and reinforce education regarding <i>the No Authorization & No Referral SOP</i> to teams regarding expectations for initial and final appeal, and/or reconsideration processes. Evaluate potential Epic functionality such as billing indicators to automatically

<p>overturn the denial due to a lack of obtaining authorization prior to services, resulting in \$174K in write-off adjustments.</p> <ul style="list-style-type: none"> 8 of 10 (80%) PB accounts did not submit an appeal and/or reconsideration request to attempt to overturn the denial due to a lack of obtaining authorization prior to services, resulting in \$20K in write-off adjustments. 2 of 25 (8%) HB accounts had an initial appeal/reconsideration submitted but did not exhaust all available follow-up opportunities to overturn the denial due to \$33K. 	<p>defined payers, benefit plans, service types, etc. based on insights from the sample testing completed and payers that offer retro-authorization.</p> <ul style="list-style-type: none"> Disseminate education supporting <i>No Authorization, No Referral SOP</i> to the PFS team that outlines expectations regarding initial and final appeal and/or reconsideration submission. Coordinate with Radiation Oncology Revenue Cycle leadership to create an SOP that outlines payers that offer retro-authorization, as well as timeframe and/or policy requirements for submitting retro-authorization. Evaluate the ability to implement identifiers within Epic, such as billing indicators or identifiers within benefit plan configuration details in Epic, to identify payers and/or benefit plans that do not allow for retro-authorization (e.g., Cigna) to prevent PFS staff from spending efforts submitting appeals on denials with no likelihood to overturn. 	<p>identify benefit plans that do not allow retro-authorization.</p> <ul style="list-style-type: none"> Collaborate with Radiation Oncology leadership to discuss retro-authorization strategy.
1.2 Root Cause Assignment	Recommendations	Management Action Plan
<p>Inconsistencies/inaccuracies were noted in appending the root cause to denial records within Epic as follows:</p> <ul style="list-style-type: none"> 2 of 25 (8%) HB accounts did not have a root cause assigned due to the system automatically closing the denial record 	<p>Revenue Cycle Operations should consider the following:</p> <ul style="list-style-type: none"> Modify the <i>Demos HB 26-28 and 31-33 Eligibility Denials SOP</i> to provide specificity regarding applicable use cases for eligibility-related root causes, as well 	<p>Action Plan Owners: Scott Smith Wathen Strong</p> <p>Action Plan Executive: Kelly Kloeckler</p>

<p>once the write-off was processed or due to user error.</p> <ul style="list-style-type: none"> • 4 of 10 (40%) PB accounts did not have a root cause assigned due to the system automatically closing the denial record once the write-off was processed. • 3 of 25 (12%) HB accounts had a root cause assigned, but a more accurate value was available. • 2 of 10 (20%) PB accounts had a root cause assigned, but a more accurate value was available. 	<p>as expectations to append a root cause on the denial record prior to processing the write-off adjustment.</p> <ul style="list-style-type: none"> • Disseminate education and supporting <i>New Adjustment Root Cause and Demos HB 26-28 and 31-33 Eligibility Denials</i> SOPs to the PFS team that outlines expectations regarding initial and final appeal and/or reconsideration submission. • Coordinate with IR to evaluate system functionality within Epic, as well as potential operational impact, to systematically require a root cause to be assigned upon closing denial records. In addition, address instances where \$0 balance denials are auto closed without a root cause by updating the SOP to clarify expectations that staff must verify the appropriate adjustment is posted and ensure the denial root cause is documented as part of the closing workflow. • Coordinate with Epic to monitor the implementation timeline for the new Epic functionality that auto-assigns denial root causes based on Claim Adjustment Reason Code (CARC). Once implemented, leverage the automation to reduce manual errors and eliminate the need for staff to manually select root causes. In the interim, continue to 	<p>Due Date: 6/30/2026</p> <p>Management will:</p> <ul style="list-style-type: none"> • Evaluate, adjust and educate teams regarding Epic’s functionality to automate denial root cause assignment. • Re-disseminate and re-enforce education regarding expectations surrounding initial and final appeal and/or reconsideration submission. • Coordinate with IR to determine feasibility and return on investment (ROI) to require root cause assignment upon Epic automatically closing denial records when the insurance balance is zero.
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	<p>validate assigned root causes for accuracy to mitigate misclassification until the automated functionality is fully developed.</p>	
1.3 Write-Off Adjustments	Recommendations	Management Action Plan
<p>The correct write-off amount and adjustment code are not consistently/appropriately utilized based on the root cause of the denial, as defined in the <i>Epic Adjustment Code List SOP</i>. The following exceptions were identified:</p> <ul style="list-style-type: none"> • 2 of 25 (8%) HB accounts incorrectly utilized a miscellaneous write-off adjustment code in Epic (OTHER DENIAL), totaling \$15K in adjustments. <p>Write-off adjustments are not consistently routed through the correct level of review and approval based on the dollar amount and originating user as outlined within SOPs and conflicting information was identified within Epic related to write-off adjustments.</p>	<p>Revenue Cycle Operations should consider the following:</p> <ul style="list-style-type: none"> • Review all testing exceptions with misclassified adjustment codes by posting staff and conduct meetings to provide education/training on appropriate code utilization. • Disseminate education and supporting <i>Epic Adjustment Code List SOP</i> to the PFS team that outlines expectations regarding appropriate adjustment code use. • Determine if the testing exceptions should be corrected to the appropriate adjustment code within Epic based on the root cause of the denial to ensure accuracy of financial reporting moving forward. • Evaluate the ability to require review and approval by a Manager/Director for all adjustments posted with a generic adjustment code (e.g., OTHER DENIALS), regardless of dollar amount. This will ensure generic adjustment codes are utilized for approved scenarios. 	<p>Action Plan Owner: Scott Smith</p> <p>Action Plan Executive: Kelly Kloeckler</p> <p>Due Date: 6/30/2026</p> <p>Management will:</p> <ul style="list-style-type: none"> • Review the testing exceptions identified from sample review with staff as part of ongoing training. Additionally, the <i>Epic Adjustment Code list SOP</i> will be disseminated to staff. • Collaborate with IR to determine the ability to limit the use of “OTHER” denial adjustment codes to Manager and above. • Review the adjustment SOPs to ensure adjustment thresholds align with configuration in Epic, which is the source of truth.

	<ul style="list-style-type: none"> Review existing SOP documentation to ensure referenced thresholds align with Epic, the designated source of truth and leadership’s expectations. All SOPs should be updated to reflect current versions of referenced documents and Epic terminology to eliminate any conflicting information between Epic and existing documentation 	
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2. Upstream Workflow Impacts
Upstream workflow errors and/or inefficiencies, such as lack of obtaining or documenting prior authorization, may result in avoidable denials and/or limit the ability for effective denial reconciliation. Inconsistent authorization obtainment and documentation processes can increase the likelihood of claims submission without valid authorization and reduce the success of downstream appeals. This can elevate the risk of delayed reimbursement, additional rework, and revenue leakage.

MEDIUM

2.1 Radiation Oncology Prior Authorization	Recommendations	Management Action Plan
<p>Prior authorization for radiation oncology services is not consistently obtained prior to patient services due to variances between the authorized dates and service dates, authorization quantity exceeded, known change in the scope of services rendered, and change in primary benefit plan. Additionally, prior authorization information is not consistently documented within both Epic and the clinical system of record, MOSAIQ, according to management expectation. Testing identified the following:</p>	<p>Radiation Oncology Management should consider the following:</p> <ul style="list-style-type: none"> Collaborate with Revenue Cycle Operations to identify the authorization data field location(s) in Epic that populate UB-04 and CMS-1500 claim formats. Coordinate IR to evaluate the ability to create a patient list/report from MOSAIQ that provides authorization information and eliminate unnecessary communication due to information not being documented within Epic. 	<p>Action Plan Owners: Alex Kerson Rhonda Benton</p> <p>Action Plan Executive: Kajal Desai</p> <p>Due Date: 9/30/2026</p> <p>Management will:</p> <ul style="list-style-type: none"> Coordinate with Revenue Cycle Operations and IR to align authorization workflows,

<ul style="list-style-type: none"> • 5 of 15 (33%) HB radiation oncology accounts did not appropriately obtain prior authorization for scheduled services. • 5 of 10 (50%) PB radiation oncology accounts did not appropriately obtain prior authorization for scheduled services. • 5 of 15 (33%) HB radiation oncology accounts did not contain documentation of prior authorization information within Epic, or the authorization number did not populate the claim due to the location it was documented within Epic. <ul style="list-style-type: none"> ○ 4 of 5 (80%) accounts did not contain the authorization number on the initial claim billed but were re-billed to include this information. • 3 of 10 (30%) PB radiation oncology accounts contained authorization information within Epic; however, the authorization number did not populate the claim due to the location it was documented within Epic. <p>Discussions with Revenue Cycle leadership noted that, although there has been an improvement within the last year, the organization continues to experience delays and unfavorable outcomes with authorization-</p>	<ul style="list-style-type: none"> • Provide education and training to Radiation Oncology Patient Access and Revenue Cycle staff to ensure authorization is submitted timely and accurately prior to scheduled services and ensure appropriate documentation of authorization information in Epic and MOSAIQ. 	<p>documentation practices, and system configurations as needed. Specifically, validate the Epic authorization data field location(s) that populate the UB-04 and CMS-1500 claim formats for Radiation Oncology services and provide education to staff accordingly.</p> <ul style="list-style-type: none"> • Coordinate with IR to assess MOSAIQ’s reporting capabilities to generate a patient list and/or report including key authorization details. • Provide targeted education and training to Radiation Oncology Patient Access and Revenue Cycle staff focused on timely authorization submission, required documentation standards, and accurate entry of authorization information in both Epic and MOSAIQ, as needed. • Partner closely with Revenue Cycle Operations to identify and outline opportunities to effectively appeal existing authorization-related denials. Additionally, measures to prevent future authorization-related denials identified from
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<p>related denials due to upstream workflow errors or inefficiencies. Epic SlicerDicer data identified the following population of initial radiation oncology authorization denials for the testing period by received date (12/1/2024 - 11/30/2025):</p> <ul style="list-style-type: none"> • HB: \$14.8M across 500 invoices • PB: \$700K across 1K invoices 		<p>this review will be implemented, as applicable.</p> <ul style="list-style-type: none"> • Explore opportunities to leverage AI tools within Epic to assist with obtaining authorization and/or confirming valid authorization exists, as available.
2.2 Insurance Verification	Recommendations	Management Action Plan
<p>Insurance verification discrepancies (e.g., limited benefit plan coverage, labor fund, etc.) are not consistently identified and reconciled due to limited information available within verification tools such as Epic Real Time Eligibility (RTE) and Availity payer/provider platform at the point of registration within the ED. Additionally, there is an opportunity to enhance staff notes and documentation within Epic to ensure financial clearance activities can be referenced by downstream teams.</p> <p>Testing of eligibility-related denials for patients admitted from the ED was completed to identify the root cause and identified the following:</p> <ul style="list-style-type: none"> • 2 of 10 (20%) HB accounts with an eligibility-related denial were verified via the Epic RTE and/or Availity during ED registration, but did not identify or reconcile benefit plan discrepancies, 	<p>Patient Access Management should consider the following:</p> <ul style="list-style-type: none"> • Identify payer plans with limited benefit plan exclusions during existing monthly denial review meetings. Utilizing verification of benefit denial data, conduct detailed review for a sample of accounts from each benefit plan to outline the information currently available within RTE responses, and what information is required for insurance verification. • Provide education to staff regarding documentation expectations when reviewing and reconciling verification responses to ensure actions and supporting information is documented within Epic. • Collaborate with Experian to explore the ability to modify RTE response details and alerts to identify patients with limited benefit plan coverage (e.g., 	<p>Action Plan Owners: Amy Curtis Stephanie Mims</p> <p>Action Plan Executive: Kelly Kloeckler</p> <p>Due Date: 1/31/2027</p> <p>Management will:</p> <ul style="list-style-type: none"> • Coordinate with Experian during biweekly meetings to ensure discrepancies between RTE and Availity are reviewed and steps are documented to ensure sources of truth align. • Re-evaluate outcome from Experian ticket #04330132 regarding RTE response information for benefit plans that offer medical and dental coverage. Pending prior

<p>resulting in \$2.1M in initial invoice-level denials.</p> <p>Additionally, Medicaid screening processes do not consistently obtain necessary coverage information (i.e., member number and card) or validate coverage effective dates prior to closing and/or resolving accounts from the workqueue.</p> <p>Testing identified the following:</p> <ul style="list-style-type: none"> 1 of 10 (10%) HB accounts with an eligibility-related denial were not completely validated during Medicaid screening processes, resulting in \$384K in initial invoice-level denials. 	<p>dental, labor funds, etc.) to proactively identify alternative funding sources.</p> <ul style="list-style-type: none"> Update the Elevate UHD ADM 05-100 SOP <i>INPATIENT SELF-PAY Eligibility Screening SOP</i> to clearly define required procedures to determine and validate active Medicaid coverage through patient outreach. Disseminate updated SOP documentation with applicable staff. 	<p>response from Experian, re-escalate the ticket during an upcoming biweekly call to revisit opportunities to adjust response information so that benefit plan limitations are appropriately identified.</p> <ul style="list-style-type: none"> The UHD ADM 05-100 SOP <i>INPATIENT SELF-PAY Eligibility Screening SOP</i> will be evaluated to include greater specificity of eligibility verification activities to ensure identified coverage is active and effective for the date(s) of service. This review will be incorporated with existing SOP review work efforts. Following completion of the review, circulate the SOP with applicable team members to ensure alignment of expectations. Coordinate with IR to determine functionality within Epic to implement user-defined/manual RTE alerts to identify discrepancies, such as limited benefit plans. Ensure the discrepancies are reviewed and reconciled by downstream teams or at the point of registration at future visits.
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Appendix A

Objective(s), Scope, and Methodology

The objectives of the review were to evaluate key internal controls to identify and reconcile denials to ensure adherence to established standard operating procedure (SOP) and industry best practice, and to ensure denials management processes (i.e., identification, reporting, root causation, resolution, and continuous monitoring) are operating effectively to reduce preventable denials and minimize write offs. Additionally, analysis was completed to identify denial trends with high-risk financial exposure and determine root causes of operational or control inefficiencies for areas that are not currently being addressed by management.

The audit scope period included activities of Revenue Cycle Operations from 12/1/2024 to 11/30/2025 (based on date of service). The review included HB and PB as well as departments with centralized and decentralized billing/denial management. The review did not include denials for services at Parkland Health and Children's Medical Center or denials related to known management initiatives.

Our procedures included but were not limited to the following:

- Interviewed key personnel and reviewed relevant organizational policies and SOPs.
- Evaluated key revenue cycle operational activities related to denial management.
- Performed analysis across a population of Epic denials data to identify and select sample areas of opportunity based on denial volume (count and dollars) and excluding existing areas of focus for management for further review and evaluation.
- Selected and tested a sample of 35 denials (15 HB Radiation Oncology Prior Authorization, 10 HB Inpatient Eligibility, and 10 PB Radiation Oncology Prior Authorization) to assess the timeliness, completeness and accuracy of denial management processes from intake, through follow-up, root causation and financial reconciliation.

We conducted our engagement in conformance with the Institute of Internal Auditors' Global Internal Audit Standards™. This report was prepared by the audit team, with some use of AI-assisted tools to support grammar and wording; all content, conclusions, and judgments reflect the work and review of the auditors.

Executive Sponsor:

Mark Meyer, Vice President and Chief Financial Officer

Key Stakeholders:

Young Chan Bae, Manager, Revenue Cycle, Data Analytics
Rhonda Benton, Radiation Oncology Revenue Cycle Manager

Amy Curtis, Director, Patient Financial Services - Patient Access
Kajal Desai, Associate Vice President Radiation Oncology Services
Carol Dutchover, Assistant Director, Professional Billing, Registration & Eligibility
Malonee Garrett, Assistant Director, Professional Billing, Technical Denials
Julie Gordon, Manager, Revenue Cycle, Quality Assurance
Alex Kerson, Radiation Oncology Finance Director
Kelly Kloeckler-Thornton, Associate Vice President, Revenue Cycle
Michael Laukaitis, Director, Revenue Cycle Accounting QA & Analytics
Stephanie Mims, Director, Patient Financial Services
Cynthia Pineda, Assistant Director, Professional Billing, Clinical Denials
Scott Smith, Director, Hospital Billing, Revenue Cycle Operations
Natalya Strachenkova, Manager, Hospital Billing, Clinical Denials
Wathen Strong, Director, Professional Billing, Revenue Cycle Operations

Audit Team:

Natalie Ramello, Vice President, Chief Compliance and Audit Officer
Philippa Krauss, Assistant Director, Internal Audit
Idris Buhidma, Project Manager, Internal Audit
Matt Jackson, Client Account Managing Director, Executive and Engagement Oversight, Protiviti, Internal Audit
Joe O'Malley, Director, Subject Matter Expert, Protiviti, Internal Audit
Rhyn Page, Client Account Lead Senior Manager, Protiviti, Internal Audit
Katherine Gavin, Senior Manager, Engagement Lead, Subject Matter Expert, Protiviti, Internal Audit
Leslie Wilson, Senior Consultant, Protiviti, Internal Audit

Appendix B

Risk Classifications & Definitions

Each observation has been assigned a risk rating according to the perceived degree of risk that exists based upon the identified deficiency combined with the subsequent priority of action to be undertaken by management. The following chart is intended to provide information with respect to the applicable definitions, color-coded depictions, and terms utilized as part of our risk ranking process:

Degree of Risk & Priority of Action	
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 UT Southwestern 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 UT Southwestern either as a whole or to a significant college / school / unit level. As such, immediate action is required by management 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 UT Southwestern either as a whole or to a college / school / unit level. As such, action is needed by management 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 UT Southwestern 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. 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 on these risks and controls in ways that this report did not and cannot anticipate.