Office of Internal Audit

UT Southwestern Medical Center

The University of Texas Southwestern Medical Center
Universal Fee Schedule Audit – MSRDP

Internal Audit Report 14:08A

November 17, 2014

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Executive Summary

Background

The Revenue Cycle consists of several interrelated components that are necessary to ensure appropriate billing and reimbursement following the provision of patient care. One of the primary components of the Revenue Cycle includes the accuracy and maintenance of the Universal Fee Schedule (UFS). The UFS is a fundamental part of reimbursement, as it provides many of the necessary data elements for compliant claims submission, including charge or service codes, narrative charge descriptions, Current Procedural Terminology (CPT) codes and modifiers, and charge amounts. The accuracy of these data elements serves as a link between service delivery, professional billing, and optimal reimbursement.

Routine maintenance of the UFS includes: the implementation of annual CPT code changes; the addition of charges applicable to new programs and procedures across the MSRDP environment; the elimination of incorrect or outdated codes, modifiers, and other data elements; and the validation of proper interfacing between applicable systems. An effective UFS maintenance process supports accurate pricing and charges for services, procedures, and supplies, and can ultimately increase savings and financial performance for the provider. The Director of MSRDP Physician and Specialty Contracting oversees the maintenance of the UFS. The Medicare Physician Fee Schedule (Fee Schedule) is an important reference for the UFS. The Fee Schedule is published by the Centers for Medicare and Medicaid Services (CMS) and provides information on services Medicare will reimburse physicians for performing based on location (i.e., facility or non-facility).

Scope and Objectives

As part of the 2014 Internal Audit Plan, a UFS Audit was performed for University of Texas Southwestern Medical Center (Medical Center) Medical Service, Research, and Development Plan (MSRDP), the group responsible for the maintenance of the professional fee schedule (i.e., UFS) utilized for physician billing. Fieldwork was initiated, performed, and completed during July – September 2014 and consisted of the following primary objectives:

- Gain a baseline understanding of the management/maintenance processes for the UFS and assess the processes implemented to evaluate the sufficiency of controls to ensure proper maintenance of the UFS for overall integrity.
- Perform limited testing of the UFS to ensure compliance with the Medical Center's established policies and procedures and to ensure accuracy or congruency with regulatory updates.
- Determine the process used to establish and review prices and assess whether the processes are appropriate to ensure that the prices are competitive with the market, consistent with cost and fee screens, and reviewed on an annual basis.

Conclusion

Operational opportunities exist to strengthen the existing control environment and ensure completeness and accuracy of the UFS. Strengths identified included an annual price rebase occurring for codes with Medicare and/or Managed Care pricing to ensure charges are appropriate and in-line with established policies and strategic pricing methodologies.

Executive Summary

Included in the table below is a summary of the observations noted, along with the respective disposition of these observations within the UTSW internal audit risk definition and classification process.

High (0)	Medium/High (0)	Medium (5)	Low (1)	Total (6)

The key improvement opportunities noted and risk-ranked as medium are summarized below.

- **UFS Maintenance** – 4,891 codes in the UFS were either expired (2,286) or not payable by Medicare (2,605). Per leadership, some of these codes are payable under certain managed care contracts. Charging for expired/non-payable codes can increase denials and result in inaccurate billing/reimbursement. Invalid codes in the UFS can also increase the risk of inaccurate charge capture. Additionally, 68% of the UFS charge codes were not utilized between July 1, 2013 and June 30, 2014, indicating extraneous active charge codes in the UFS that could potentially be selected in error.

- **Miscellaneous Charge Codes and Charge Override Access** – Miscellaneous charge codes and charge overrides are utilized as a standard practice within the UFS for professional fee charging and monitoring controls do not exist to ensure charge override amounts are appropriate. This can result in erroneous or inconsistent charging or charges less than the standard reimbursement allowed amount. A total of 111 users have charge override access to 5,243 charge codes within Epic. Office visits are included in this list, which is more risky than other items such as laboratory or pharmacy.

- **Invalid/Missing Modifiers** – 222 codes appeared to have an invalid modifier or were missing a necessary modifier, which can result in inaccurate billing/reimbursement and potential denials. Modifiers are utilized in medical billing to alter the description of a service or supply provided. Seven of these codes were charged 67 times during 1/1/2014 to 6/30/2014 for a total gross revenue charge amount of approximately $41,000.

- **Charges Below Medicare Reimbursement Rates** – Audit identified 16 charges below the Medicare rate. These charge amounts would have resulted in missed reimbursement of $36,385 from 1/1/2014 – 6/30/2014 based on the number of times the code was charged, assuming Medicare reimbursement rates. 15 out of 16 (94%) of the charge codes identified were on a “known exceptions” list created and maintained by MSRDP; however, many of the exceptions granted in prior years have not been revisited since 2010 and documentation of approval was not available.

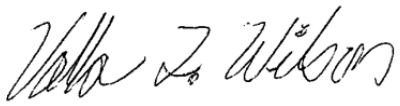
- **UFS Change Request Process** – The UFS change request process is not standardized and does not support documentation retention related to change requests, data integrity to ensure the accurate change is made, work queue monitoring, timely change management, or reporting.

Management has begun to address the issues identified in the report and, in some cases, implemented recommendations. These responses, along with additional details for each of the key improvement opportunities listed above and other lower risk observations are listed in the Detailed Observations and Action Plans Matrix (Matrix) section of this report.

We would like to thank the departments and individuals included in this audit for the courtesies extended to us and for their cooperation during our review.

Executive Summary

Sincerely,



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Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium 1. **UFS Maintenance** 4,891 codes in the UFS were expired (2,286) or not payable by Medicare (2,605). These charge codes encompassed various categories, including but not limited to audiology, biological/pharmaceutical, dental, durable medical equipment (DME), hospice, optometry, radiology, and surgery. Per leadership, some of these codes are payable under certain managed care contracts. Charging for expired/non-payable codes can increase denials and result in inaccurate billing/reimbursement. Invalid codes in the UFS can also increase the risk of inaccurate charge capture. Codes identified as expired were not charged in the first two quarters of 2014. 382 of the codes identified as not payable by Medicare were charged to various payors, including Medicare, approximately 114,000 times during January through June 2014 for a total gross revenue charge amount of approximately $26 million (excluding any charge override amounts). Please note that 98% of these codes were charged to patients with managed care payors. The 2% charged to patients with Medicare coverage may also include patients with dual eligibility (Medicare eligible with additional managed care coverage). Additionally, 68% of the charge codes in the UFS were not utilized between 7/1/2013 and 6/30/2014, indicating extraneous active charge codes in the UFS that could potentially be selected in error.	1. Review the list of codes identified for validity, appropriateness, and usage to determine whether the code should remain in the UFS based on licensure or managed care contracts, be terminated (i.e., deactivated), or replaced with a valid code. For example, blood and blood products should typically only be administered by institutional providers; as a result, these should be critically evaluated for appropriateness. This review should be prioritized based on codes with usage. 2. Review charges with no usage in the past two years and analyze whether these codes should be terminated, limiting the risk of inaccurate charges being selected and added to patient accounts. 3. Update the UFS as the evaluation process is completed and appropriate approval is obtained. 4. Determine any billing impact from codes determined to be invalid and evaluate whether rebill is necessary. 5. Going forward, review the quarterly Medicare releases and update the UFS regularly to ensure invalid codes are identified as they are updated and moved to a terminated status in a timely manner. Consider implementing automated tools, as appropriate, to assist in scrubbing the UFS for regulatory updates and/or appropriateness. A standard revenue and usage report should be developed and used on an annual basis to identify codes that are not utilized within 12 months to ensure they are moved to an inactive status, unless there is a strong reason a specific code should	**Action Plan Owner:** Director, MSRDP Physician and Specialty Contracting Senior Financial Analyst, MSRDP Business Operations **Target Completion Date:** 1-5. February 28, 2015 **Management Action Plan:** MSRDP agrees to add evaluation and processes where necessary to trim potential risk from the UFS. 1. MSRDP agrees the UFS process can be refined to consider and work with IR to build Charge Review Edits for invalid or deactivated Medicare codes at a global or payor level. We will conduct a review of all potentially invalid codes identified and provide a recommendation to the Revenue Cycle Committee (RCC) regarding the appropriate action to take. Our target completion date is February 28, 2015. 2. We agree that a review and/or recommendation to the RCC be made based on review of two years' data. The RCC will review the recommendation and make the final determination regarding the appropriate action(s) to take. Our target completion date is February 28, 2015. 3. The UFS will be updated based on the RCC's determinations. Our target completion date is February 28, 2015. 4. Billing impact from invalid codes will be reviewed and determine if rebilling is necessary. Our target completion date is February 28, 2015.

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
	remain active.	5. Quarterly drug updates will be reviewed to determine codes no longer valid and terminate them going forward for Medicare or other payors as applicable. Agree to either terminate or deactivate codes without utilization. Our target completion date is February 28, 2015.
Risk Rating: Medium 2. **Miscellaneous Charge Codes and Charge Override Access** Miscellaneous charge codes and charge overrides are utilized as a standard practice within the UFS for professional fee charging and monitoring controls do not exist to ensure charge override amounts are appropriate. This can result in erroneous or inconsistent charging or charges less than the standard reimbursement allowed amount. Specific details include the following: • A total of 111 users have charge override access to 5,243 charge codes within Epic. Office visits are included in this list, which is more risky than other items such as laboratory or pharmacy. • During testing, Audit noted an invoice in Epic where CPT code 93641-26 was overwritten because a charge was not present in the UFS. The correct process for a department to follow when a charge does not exist in the UFS is to contact the UFS Analyst so that appropriate price research and system set-up can occur, but this did not occur. Furthermore, the overwritten charge amount ($916) was less than the allowed amount by the payor ($1,024.50).	1. Determine whether charge codes without an assigned charge amount can be modified to include a charge amount based on payor pricing, available competitor data, or other methodology to prevent future overrides. 2. Review user access to override charge codes as well as charge codes able to be overridden to ensure appropriateness. 3. Adjust user security/charge override configuration based on findings. 4. Implement a mechanism for monitoring charge overrides to ensure an appropriate amount is charged/billed. 5. Include information in the procedure document regarding when a charge override is appropriate, including titles, charge detail, etc.	**Action Plan Owner:** Director, MSRDP Physician and Specialty Contracting Associate Director, Practice Plan Information Resources Manager, Health Systems Information Resources Senior Financial Analyst, MSRDP Business Operations **Target Completion Date:** 1a. February 28, 2015 1b. April 30, 2015 2. January 31, 2015 3. February 28, 2015 4. March 31, 2015 5. May 31, 2015 **Management Action Plan:** MSRDP and Information Resources (IR) will work together to assess the ability to determine charges for unpriced codes and categorize accordingly. For those that could be priced, we will consider options to set a price that would not have a negative impact if the “starting” price was not overridden. This will also include user level and code level restrictions that may restrict pricing used and limit risk of undesired overrides.

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
		1. MSRDP will pull all override codes and separate into those priced and those that cannot be priced by February 28, 2015. For those that cannot, deactivation or other control measures will be considered. We will review the charge codes to determine whether a standard price can be applied to prevent future overrides by April 30, 2015. 2. Both the override code and user lists will be reviewed periodically. We will review user access security and charges being overridden for appropriateness. Our target completion date is January 31, 2015. 3. Recommendations will be made for changes and communicated as part of the UFS rebase process. Access to user overrides and charges available for override will be updated as identified in item #2 above. Our target completion date is February 28, 2015. 4. Similar to exceptions, override data will be reviewed and reported. We will develop a report to monitor all charge overrides. All charge overrides will be reviewed by department based on frequency and charge impact. Our target completion date is March 31, 2015. 5. The procedure document will be updated with specific information related to charge overrides. Our target completion date is May 31, 2015.
Risk Rating: Medium 3. **Invalid/Missing Modifiers** 222 codes appeared to have an invalid modifier or were missing a necessary modifier, which can result in inaccurate billing/reimbursement and potential denials. Modifiers are utilized in medical billing to	1. Review the list of potentially invalid/missing modifiers for validity, appropriateness, and usage to determine the appropriate action. 2. Update the UFS as the evaluation process is completed and appropriate approval is obtained.	**Action Plan Owner:** Director, MSRDP Physician and Specialty Contracting Senior Financial Analyst, MSRDP Business Operations

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
alter the description of a service or supply provided. Specific examples are as follows: • 154 out of 222 codes with errors are DME codes without the appropriate modifiers attached. • 40 out of 222 codes with errors require modifier 26 because there is no "global" rate payable per the Fee Schedule. • 20 out of 222 codes with errors are valid CPT codes with modifier 26, even though the professional component is not separately payable under the Fee Schedule. • 8 out of 222 codes with errors are set up with modifier 20, which is no longer a valid modifier. 7 of the 222 codes were charged 67 times during 1/1/2014 to 6/30/2014 for a total gross revenue charge amount of $40,913 in the following categories: one DME code without the appropriate modifier attached; four codes that require modifier 26; and two codes that are not payable with a modifier 26.	3. Determine any billing impact from invalid/missing modifiers to evaluate whether rebill is necessary.	**Target Completion Date:** 1-3. February 28, 2015 **Management Action Plan:** Similar to general codes being invalid or non-Medicare priced, MSRDP agrees to add evaluations and process where necessary to trim potential risk from the UFS. 1. MSRDP agrees that the UFS process can be refined to consider invalid Medicare modifiers to terminate or deactivate at a global or payor level. We will conduct a review of all potentially invalid or missing modifiers identified and provide a recommendation to the Revenue Cycle Committee (RCC) regarding the appropriate action to take. Our target completion date is February 28, 2015. 2. Review and communicate to RCC or Billing Operations as necessary for implementation of recommended action. The RCC will review the recommendation and make the final determination regarding the appropriate action(s) to take. Our target completion date is February 28, 2015. 3. MSRDP will communicate improper billing impacts to Billing Operations to determine and initiate appropriate rebills. Our target completion date is February 28, 2015.
Risk Rating: Medium 4. **Charges Below Medicare Reimbursement Rates** 16 charges were below the Medicare reimbursement rate. These charge amounts resulted in missed reimbursement of $36,385 from 1/1/2014 – 6/30/2014 based on the number of times the code was charged, assuming Medicare	1. Perform an annual review of charges on the "known exception" list to ensure the standard charge methodology exceptions remain appropriate. Maintain documentation of department and/or RCC approval for exceptions or update charge as deemed appropriate. 2. Update the charge amount for the charge	**Action Plan Owner:** Director, MSRDP Physician and Specialty Contracting Senior Financial Analyst, MSRDP Business Operations **Target Completion Date:**

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
reimbursement rates. • 10 out of 16 (62%) have a charge lower than non-facility but higher than facility Medicare reimbursement rates. These charge codes were charged a total of 145 times (2 times at the non-facility rate, 143 times at the facility rate) during 1/1/2014 – 6/30/2014. Assuming Medicare reimbursement, the charge amount resulted in missed reimbursement of $11,523. • 6 out of 16 (38%) charge codes have a charge lower than both the non-facility and facility Medicare reimbursement rates. These charge codes were charged a total of 442 times (all at the non-facility rate) during 1/1/2014 – 6/30/2014. Assuming Medicare reimbursement, the charge amount resulted in missed reimbursement of $24,862. After reviewing with the MSRDP Physician and Specialty Contracting department, Audit determined 15 out of 16 (94%) of the charge codes identified were on a "known exception" list created and maintained by MSRDP; however, many of the exceptions granted in prior years have not been revisited since 2010 and documentation of approval was not available.	code confirmed to have a price below the Fee Schedule non-facility rate to be in line with standard charge protocols.	1. February 28, 2015 2. Complete **Management Action Plan:** MSRDP can distribute a report to the departments with codes impacted by the exception list to confirm the need to sustain current pricing level or adjust based on standard pricing and charge impact. 1. MSRDP agrees that carrying exceptions forward through reporting is important as rationale and impact may vary over time. All "known exceptions" will be validated prior to the annual rebase analysis process and approval will be obtained each year as necessary. Our target completion date is February 28, 2015. 2. The charge code not included on the "known exception" list confirmed to have a price below the Fee Schedule non-facility rate has been updated in line with standard charge protocols. This has been completed.
Risk Rating: Medium 5. **UFS Change Request Process** The UFS change request process is not standardized and does not support documentation retention related to change requests, data integrity to ensure the accurate change is made, work queue monitoring, timely change management, or reporting.	1. Create a formalized policy/procedure regarding the UFS change request process, including the appropriate protocols and approval required for various types of changes. 2. Implement an automated request form in Service Now for the departments to request UFS adds/edits. The form should require specific fields be completed in order to	**Action Plan Owner:** Associate Director, Practice Plan Information Resources Director, MSRDP Physician and Specialty Contracting Manager, Health Systems Information Resources Software System Specialist, Health Systems

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
• A standard request form/tracking system does not exist to ensure completeness of information and timely completion of a change request. • Two examples of untimely change management were identified; each of these requests was outstanding for more than 30 days. Untimely change requests can impact charge capture and reimbursement. • A formalized policy or procedure does not exist to document the expected UFS change request process.	create an IR ticket in the Service Now system. The UFS Analyst should utilize Service Now to document all correspondence and pricing analysis detail within each incident to ensure communication from all parties is maintained together. A memo and any appropriate training should be provided to department billing staff once the new process is established. 3. Develop tracking metrics and goals, such as timeliness of turnaround for charge add/edit requests. Track, trend, and report metrics to the appropriate individuals as necessary and implement action plans to improve as needed.	Information Resources Senior Financial Analyst, MSRDP Business Operations **Target Completion Date:** 1. January 31, 2015 2. May 31, 2015 3. August 31, 2015 **Management Action Plan:** IR and MSRDP will work together to align the process to the Service Now capabilities and develop a more connected process for UFS changes. 1. IR will enhance the existing UFS ticket process to thread relevant approvals and closure accordingly. A formal document will be developed regarding the UFS change request process. Our target completion date is January 31, 2015. 2. Enhancements to the UFS changes will include the use of Service Now capabilities to capture request or change initiation, communication, relevant documentation, and approvals. The expected UFS change request process will be updated to follow a Service Now protocol. The request will be initiated in Service Now through an automated form and all documentation will be maintained through Service Now. Our target completion date is May 31, 2015. 3. The capabilities will also be used to indicate volume and completion / disposal of requests. Reports or activity information will be reported and reviewed to determine process or efficiency changes. Additionally, documentation and communication of final processes and necessary training will be performed. Our target

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
		completion date is August 31, 2015.
Risk Rating: Low 6. **Price Establishment Protocols** The process for establishing charge code prices outside of the standard methodology is not consistent and/or appropriate. Specifically, for items without standard Medicare and/or Managed Care pricing, the UFS Analyst relies on pricing established by the department without performing additional analysis or requiring additional approval. In addition, the current process for performing the standard pricing methodology calculation is highly manual and susceptible to error.	1. Update the existing procedure document to include detailed information regarding the UFS standard and non-standard pricing methodologies, including approvals required for non-standard pricing and/or pricing exceptions. 2. Require additional analysis and approval on proposed non-standard pricing. While it is appropriate to take the departments' pricing feedback into consideration, additional analysis and approval should be required on proposed non-standard pricing, potentially from the department's director or the RCC. This should be consistent with current price decrease requirements. All analysis and approval should be documented. 3. Evaluate existing needs and expansion of tools (e.g., MedAssets Charge Master Tool) to assist with pricing methodology calculations. Include this information within the Service Now incident (see observation #5) as a quality assurance/double check of the price accuracy.	**Action Plan Owner:** Director, MSRDP Physician and Specialty Contracting Senior Financial Analyst, MSRDP Business Operations **Target Completion Date:** 1-2. February 28, 2015 2. August 31, 2015 **Management Action Plan:** 1. MSRDP will update the UFS policy to further clarify the specifics related to standard and non-standard pricing and the maintenance of exceptions. Our target completion date is February 28, 2015. 2. MSRDP will update the UFS policy to indicate analysis and approval of non-standard pricing and annual rebasing exception validation and RCC approval. Our target completion date is February 28, 2015. 3. As the UFS process has many moving parts, MSRDP will evaluate opportunities to create and utilize automated tools to assist with key UFS rebasing activities. Our target completion date is August 31, 2015.

Appendix A – Risk Definition and Classification Process

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.	**High**	The degree of risk is unacceptable and either does or could pose a significant level of exposure to the organization. As such, immediate action is required by management in order to address the noted concern and reduce risks to the organization.
	Medium/High	The degree of risk is substantially undesirable and either does or could pose a moderate to significant level of exposure to the organization. As such, prompt action by management is essential in order to address the noted concern and reduce risks to the organization.
	Medium	The degree of risk is undesirable and either does or could pose a moderate level of exposure to the organization. As such, action is needed by management in order to address the noted concern and reduce risks to a more desirable level.
	Low	The degree of risk appears reasonable; however, opportunities exist to further reduce risks through improvement of existing policies, procedures, and/or operations. 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 subsequent 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.