13-108 Charge Capture Review – Division of Surgery

Strategic Area: Patient Care
Risk Type: Financial, Operational
Audit Manager: Mary Ann Waterman

Overview:
The Division of Surgery is comprised of eight departments representing multiple surgical sub-specialties, staffed with 116 faculty supported by approximately 173 trainees and 138 mid-level providers. During FY 2012, 18,937 primary surgical cases were performed in the operating room generating total gross patient professional revenue of over $259 million.

From January through August 2012, the Division posted $175 million in professional gross revenue, with 67% of that generated by the top three revenue generating departments we reviewed: Surgical Oncology, Plastic Surgery and Urology. The Division’s administration recognizes the importance of, and has implemented new processes to ensure, complete, accurate and timely charge capture. A Charge Capture Efficiency Team was formed to identify and implement process and policy improvements. During this audit, the Division continued to identify potential practice improvements and collaborated with the audit team for immediate implementation, as warranted.

Audit Results Summary:
Current institutional policies and procedures across the charge capture continuum do not ensure that all operating room professional encounters are accurately charged, authorized, and complete. Manual calculation and/or recording of charge data results in errors posted to patient accounts. Controls are not effectively designed to reduce the likelihood of exporting gross patient charges to the professional billing system prior to final sign off of the operative report. Reconciliation procedures are not implemented at each interface between the automated systems to ensure that all scheduled cases are transferred for billing. Policy and procedure improvements should include:

- minimizing manual entry of charge data and implementing a review process to ensure manually recorded charges are accurate;
- assuring billed charges are authorized by signed operative reports prior to billing;
- reconciling each automated system interface to ensure completed surgical cases have been coded and billed; and,
- reconciling scheduled services to gross professional revenues.

Management Summary Response:
Management has agreed to improve monitoring, enforcement, and reconciliation controls to ensure the proper and accurate capturing of surgery professional charges. In addition, appropriate reimbursements for over charges will be made.

Number of recommendations to be monitored by UT System: 0
Objective, Scope and Methodology:

The objective of this engagement was to determine whether professional services performed in the operating room (OR) were captured and recorded appropriately in the institution's charge capture application and that gross charges were accurately reflected on the patient account. Our scope of work was limited to the internal controls implemented to capture and record professional charges for OR surgical services provided by Surgical Oncology, Plastic Surgery and Urology for the period of January through August 2012. We did not review any technical charges associated with the surgical case.

Audit procedures included, but were not limited to:

- Review of institutional policy related to charge capture for surgical services. Key institutional policies included: CLN 0481 Operative Notes Dictation Policy; CLN 0555 Medical Documentation Policy; CLN 0510 Document Completion Penalty Policy; and the UT MDACC Rules and Regulations of the Medical Staff.

- Review of existing Division and Department draft guidance related to charge capture and the use of OR Manager, MedAptus, Charge Description Master (CDM) and IDX automated systems.

- Interviews with Division faculty administrators to determine their role and responsibility in the overall charge capture process.

- Interviews with Division and Department management and staff to gain an understanding of processes and controls used to ensure charges are properly recorded and billed.

- Interviews with Revenue Capture and Support management and observation of work performed by coding personnel.

- Review of reports used to monitor the charge capture process.

- Testing of scheduled procedures to determine whether charges were authorized and appropriately captured.

- Independent comparison of the OR Manager population of operative encounters to the population of gross charges captured in IDX. The period under review was limited to the fourth quarter of fiscal 2012. We matched each instance by patient medical record number, date of service and provider.

Our review was conducted in accordance with the International Standards for the Professional Practice of Internal Auditing.

The courtesy and cooperation extended by personnel from the Division of Surgery and Revenue Capture and Support is sincerely appreciated.

Sherri Magnus, CPA, CIA, CFE, CRMA
Vice President and Chief Audit Officer
June 17, 2013
Background

The charge capture process begins when surgical procedures are scheduled, continues through documentation of the services performed, and culminates with recording of gross patient charges in the billing system. Four automated systems manage this process:

- OR Manager is a comprehensive system with modules used for surgery scheduling and documentation of activity in the operating room;
- MedAptus is primarily a charge capture system also used to assign procedure coding;
- Charge Description Master (CDM) houses the institution’s authorized fee schedule for services and goods charged to patient accounts; and,
- IDX is the billing system for professional charges.

Complete and accurate charge capture is dependent on oversight and collaboration between the Division of Surgery and Revenue Capture and Support. Subsequent to the surgical procedure, the surgeon dictates an operative report that must be transcribed and subsequently finalized by the physician’s signature in the electronic medical record. This key medical record document authorizes the gross charges billed. Revenue Capture and Support coding personnel access the transcribed operative report in order to interpret and assign standard current procedural terminology (CPT) codes in MedAptus. As CPT codes are assigned, coders may determine whether the case requires a modifier code to more accurately describe resources used during the procedure (i.e. the level of complexity, additional surgeons, etc.).

In addition to assigning CPT codes, surgical coders access the CDM to determine the fee assigned for that specific procedure and then documents the charge amount in a free text field in MedAptus. Two modifiers, when applicable to a case, impact the base fee and require the surgical coder to manually calculate the adjusted dollar amount. Once the case has been coded, the surgeon has an opportunity to review the MedAptus documentation for accuracy and completeness prior to the coder’s decision to export the encounter to the billing system (IDX).

To support the quality of coded charges, the Division assigned each department a Faculty Coding Liaison to facilitate discussion between coding personnel and physicians as well as improve medical record documentation through timely communication and education.

To more effectively support each department’s financial administration and oversight, a Clinical Billing Specialist position in Surgical Oncology was used to build the staffing model for future positions. The Clinical Billing Specialist is primarily responsible for ensuring compliance with internal procedures for charge capture related to posting, timely review and processing. As the departmental liaison, the specialist will facilitate conversations and education sessions between the coders and physicians to assist in streamlining the coding process. During December 2012, the Division received executive approval to begin hiring four positions to fulfill this functional role.

Observation 1:

**Accuracy of Professional Gross Charges**

As noted earlier, surgical CPT codes have an authorized base price that is maintained in the CDM fee schedule and during the coding process charges are manually entered in MedAptus by the surgical coder. When certain case modifiers are present, the professional gross charge is
adjusted upward through a manual calculation also performed by the coder. The manual charge recording procedure being used overrides the automated posting of the price in the CDM to the patient account. There are no automated edits in IDX to identify manual calculation or data entry errors. Based on interviews with coding personnel and Division administration, there are no controls established to monitor and ensure professional gross charges are accurate.

We analyzed professional operating room gross charges posted to patient accounts for the period of January 1, 2012 through August 31, 2012. By independently comparing the approved fee schedule with actual posted charges for 6873 patient records, we identified 672 records with a variance from the expected charge based on the procedures coded. Of the 672 records, we selected 145 (22%) for further review.

Of the 145 records reviewed, 55 (38%) of the charges appear to be inaccurate resulting in over and under charges to patient accounts. We identified over charges of $189,337 and under charges of $203,742 in our limited sample. Further review is required to determine the full impact on patient accounts.

The institution’s risk of inaccurate charge capture for surgical cases would be significantly reduced by restricting manual entry of surgical case charge amounts during the coding process. Manual intervention and recording of charges will still occur for complex surgical cases or those that are assigned certain modifiers that impact the authorized CDM fee schedule.

Recommendation 1.1:
The Division of Surgery should work in collaboration with Revenue Capture and Support to restrict the manual input of CPT charge values at the time an operative case is coded to only those cases requiring a calculated modifier adjustment or unique professional charge not listed in the CDM fee schedule. Periodic monitoring controls should be developed, documented and implemented by the Division to ensure accuracy of charges posted for cases requiring manually calculated gross charges.

Management’s Action Plan:
Responsible EVP: Thomas Burke, M.D.
Action Plan Owner: Renee Konstanzer
Due Date: July 31, 2013

As of March 1, 2013, Revenue Capture and Support discontinued the manual practice of adding CPT code charges into MedAptus with the support of the Division of Surgery. However, when modifiers are added to codes, dollar amounts associated with these modifiers are manually entered into MedAptus. In this case, the risk of inaccurate charges being posted to patient accounts without detection still exists. While the responsibility for appropriate charge assignment belongs to Revenue Capture and Support, the Division of Surgery has an interest in ensuring that its divisional revenue is accurate. The Division of Surgery will develop and implement a monitoring process that will periodically sample and audit charges with modifier assignment in the EIW, to ensure the accuracy of charge capture.
Recommendation 1.2:
Revenue Capture and Support should review all potential over charges and ensure that appropriate reimbursements are made.

Management’s Action Plan:
Responsible EVP: Leon Leach, PhD
Action Plan Owner: Lori English
Due Date: August 31, 2013

Revenue Capture and Support along with Patient Business Services will review potential over charges and determine and make appropriate refunds.

Observation 2:
Timeliness of Dictated Operative Reports

The institution has formal policy statements governing how operative reports and other medical record information must be documented. We noted throughout this project, that existing policy statements describe a time frame (typically measured as 24 hours) for dictating the operative report. The policy also indicates that delinquent operative notes will result in suspension of access to the surgical schedule for the attending surgeon of record.

Monitoring for the delinquent initiation of operative reports is being conducted by the Division with notifications sent to providers for delinquent performance; however, it is not performed consistently. In addition, surgeons were not being removed from the surgery schedule when reports were delinquent.

Recommendation 2:
Division of Surgery management should ensure operative reports are dictated within the timelines outlined in current policy. For those dictations that are delinquent, sanctions defined by policy should be enforced.

Management’s Action Plan:
Responsible EVP: Thomas Burke, M.D.
Action Plan Owner: Renee Konstanzer
Due Date: August 31, 2013

The Division of Surgery will assess the current policies impacting operative notes and work with divisional and HIM leadership to address feasibility. If policy changes to are recommended due to implementation concerns or patient safety, the Division of Surgery will appropriately forward those changes through policy governance. In the interim, the Division of Surgery will establish a reasonable and consistent process for operative note dictation enforcement practice with the support of the Division of Surgery Executive Committee (surgical chairs).
Observation 3:

**Complete Charge Capture**

Division of Surgery management recognizes the importance of complete and accurate charge capture. During FY 2012, control gaps were identified and process improvements initiated to ensure complete, accurate, and timely charge capture. In addition to the creation of the Charge Capture Efficiency team, management coordinated with Clinical Analytics and Informatics to develop reports that would assist the Division's recognition of incomplete data and charge discrepancies in OR Manager prior to export to MedAptus.

There is, however, no formal reconciliation process when scheduled operative procedures in OR Manager are interfaced to MedAptus to ensure that all services provided were captured for coding. The Division's administration is currently coordinating with Clinical Analytics and Informatics to develop a report that would assist in the interface reconciliation process.

The existence and effectiveness of control over the interface between MedAptus and IDX to ensure that all coded cases are billed was reviewed during last year's Audit #2012-404, MedAptus Application Review. Management's action plan to implement an appropriate interface reconciliation process is still in progress at this time.

During the transfer of files from MedAptus to IDX, certain edits exist and are reported on the Transaction Editing System Report (TES). We reviewed a recent TES report and noted that coders are correcting identified errors and stale items were not evident. For the period under review, we identified less than one percent of completed cases scheduled in OR Manager that were never posted to IDX.

**Recommendation 3:**
The Division of Surgery should develop and implement a process to ensure that all cases are transferred at the interface from OR Manager to MedAptus appropriately. The detailed procedures should include assignment of accountability for identifying and timely resolving any discrepancies or errors.

Once reconciliation procedures related to system interfaces are complete, the Division should document and implement a financial reconciliation process based on institutional guidelines to ensure all scheduled procedures are accounted for and properly reflected in departmental gross revenue.
Management's Action Plan:
Responsible EVP: Thomas Burke, M.D.
Action Plan Owner: Renee Konstanzer
Due Date: May 31, 2013

In collaboration with Clinical Analytics & Informatics, the Division of Surgery has implemented a process to ensure all cases from OR Manager interface successfully with MedAptus. This is being accomplished through the use of a daily reconciliation exception report that is e-mailed to the appropriate staff in the Division of Surgery and Revenue Capture and Support. This report identifies any cases that did not interface to MedAptus from the cases performed the previous day, and any cases identified on the report are added to MedAptus by Revenue Capture and Support. The report displays the following information:

a. MRN
b. Date of Service
c. Case Number
d. Surgeon Name
e. Surgeon Service
f. OR Room
g. Count of any Missing Cases - Defined as a surgical case that exists in OR Manager but not in MedAptus.

A second reconciliation is performed on a monthly basis to ensure all scheduled procedures are accounted for in the departmental gross revenue. The report reconciles actual cases performed from the month prior in OR Manager to the cases posted in IDX by surgeon name, date of service and MRN. Any discrepancies are investigated and resolved by contacting the department and/or sending the case information to Revenue Capture and Support for billing purposes.

These reports are currently in active use. The interim time between now and May 31, 2013 will allow us to test and document our reconciliation process for consistency and feasibility.

Observation 4:
**System Access and Segregation of Duties**

To mitigate the risk of unauthorized, unsupported or fraudulent charges for surgical services we examined controls currently implemented through restricted access to the MedAptus application. During the project planning phase, we reviewed work performed last year by the Internal Audit IT team and noted the issues, identified in Audit #2012-404 MedAptus Application Review, were relevant to this project. To further assess risk for the Division of Surgery, we identified 2 instances of assigned system access for individuals who do not need access to perform their job functions. For a sample of Division users, we also confirmed there were no apparent assignments of dual MedAptus user roles that might present a segregation of duties issue.

Revenue Capture and Support management is addressing the control deficiencies cited in the earlier report. No further specific recommendation for the Division is being made as a result of this current review.