14-211 Change of Management Review – Plastic Surgery

Strategic Area: Operational
Risk Type: Operational, Financial, Compliance
Audit Manager: Veronica Kasdorf

Overview:
Reconstructive Surgery was introduced to the University of Texas MD Anderson Cancer Center (the Institution) in 1988 through the establishment of the first microsurgical team. Within six years, the Department of Plastic Surgery (the Department) was formed with a group of surgeons and other healthcare experts dedicated to restoring form and function to cancer patients. The recently appointed Faculty Chair has a team of over 45 faculty and clinical staff. It is the second largest revenue generating department within the Division of Surgery, generating more than $71 million in gross charges for fiscal year 2013, 22 percent of the Division’s gross charges for the same time period.

The Department’s multi-disciplinary research program concentrates on enhancing quality of life issues for cancer survivors by integrating knowledge from clinical science, life science, and engineering fields. The Department has one grant award funded by the National Institute of Health as well as several other awards for educational programs. Eighteen research staff supports the efforts of the Department’s principal investigators.

Figures provided by Division of Surgery and have not been audited
Audit Results Summary:
At the request of management, Internal Audit performed a general assessment of internal controls over key administrative functions within the Department of Plastic Surgery. The Department recognized the need for enhanced monitoring and control processes and acquired financial support staff during the course of this review.

While controls over certain key functions are in place, our review identified opportunities for improvement in the following areas:

- Ensuring accurate and timely effort reporting
- Enhancing controls over leave management
- Disclosing potential conflict of interest
- Management of deficit accounts
- Reconciliation of grant accounts
- Monitoring system access

Management Summary Response:
Management agreed with the observations and recommendations in this report and began to implement corrective actions prior to the release of this report. They are developing additional departmental procedures to ensure key controls are functioning as intended.

Number of Priority Findings to be monitored by UT System: None

A Priority Finding is defined as “an issue identified by an internal audit that, if not addressed timely, could directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole.”

Appendix A outlines the objective, scope, and methodology for this project.

The courtesy and cooperation extended by the Department of Plastic Surgery was sincerely appreciated.

Sherri Magnus, CPA, CIA, CFE, CRMA
Vice President & Chief Audit Officer
September 2, 2014
Observation 1

Effort Reporting

Federal regulation requires Principal Investigators (PI), or responsible individuals with first-hand knowledge of the research activities, to prepare reasonable estimates of effort on each grant agreement. To comply with this regulation, the Institution has developed and implemented ECRT, an effort reporting system, using effort cards that are certified quarterly for all research staff by the responsible PI. Effort Policy, ACA0016, requires certification of effort cards within thirty days after the cards are available for review.

We reviewed the Certification Status Reports from ECERT for all faculty and support staff for the 1st and 2nd quarters of fiscal year 2014. This review identified a total of 17 out of 38 (45%) effort cards that were uncertified and/or unprocessed. A review of 10 effort cards for the same time period identified three (30%) instances where individuals spent time on a sponsored project but their effort card did not reflect this. These resulted in salaries being paid from institutional funds, rather than the appropriate sponsored project. The remaining seven were not certified or processed, as indicated above.

The department does not currently have an Effort Coordinator to facilitate appropriate effort reporting. As a result, there was noncompliance with established guidelines, which could jeopardize research funding and prompt involuntary cost sharing.

Recommendation:
Management should ensure that the certified effort reflects a reasonable estimate of time spent on the project, effort is certified timely, and charged to the appropriate funding source. Instances identified during our review in which the certified effort was not accurate should be corrected.

Management’s Action Plan:
Responsible EVP: Ethan Dmitrovsky, M.D,
Owner: Melanie Lopresto
Observer: Maureen Cagley
Due Date: February 29, 2015

The uncertified effort cards identified as part of the review will be completed. Formerly, when pay did not match the certified effort on the effort card, the card was not processed to ensure that retroactive personnel actions could be successfully processed. This practice will be discontinued and going forward effort cards will be certified in accordance to institutional policy. Additionally, salary will be more closely monitored to prevent the need to process retro-active personnel actions. Management also plans to consult with other departments to identify best practices that can improve our performance in this area.
Observation 2:
**Leave Management**

The Institutional Attendance Policy, ADM0289, requires management to establish and monitor departmental timekeeping procedures and to accurately and timely capture employee leave into the appropriate source systems. The Plastic Surgery departmental calendar is utilized by faculty and staff to capture leave requests. Using the departmental calendar, the timekeepers enter leave into Kronos (the institution's official timekeeping system). During our review of leave management, we identified the following:

- Approximately 30% of the Department’s weekly Kronos time reports for the second quarter of fiscal year 2014 were not approved by management.
- Approximately 174 leave hours for 13 non-faculty employees were not captured in Kronos during our scope period. Missing leave examples include Paid Time Off (PTO), Leave Without Pay and Extended Illness Bank.

**Recommendation:**
Management should enhance its leave practices to ensure that all leave is reviewed for completeness, accuracy and timeliness. The exceptions identified should be properly recorded in Kronos.

**Management’s Action Plan:**
Responsible EVP: Thomas Buchholz. M.D.
Owner: Melanie Lopresto
Observer: Wenonah Ecung
Due Date: February 29, 2015

*Management is in the process of correcting all of the leave issues that were identified in the review. Kronos corrections are in progress. Management will implement stronger controls to document exceptions. We will identify the causes for these exceptions and implement controls to prevent these errors from occurring. It will be stressed that requests for time off are canceled as necessary and all requests are approved in a timely manner. A stronger review process will also be implemented to ensure that no requests are missed.*

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Observation 3: Extramural Leave

According to the Faculty Extramural Leave Policy (ACA0051), extramural leave is time away from the Institution utilized by an eligible faculty member to pursue external professional activities or interests with or without personal financial gain. All extramural leave requests must be approved in advance, recorded in Kronos, and may not exceed 30 working days in any fiscal year. Extramural days exceeding these limits must be approved by the Office of the Provost.

We reviewed extramural leave for 12 (52%) faculty within Plastic Surgery and noted that 9 faculty (75%) require Kronos corrections due to extramural leave not being recorded appropriately. There were 19 extramural leave days that were not captured, 17 extramural leave days that were overstated in Kronos, and 11 uncaptured PTO days. Total extramural leave days for all faculty within the Department did not exceed the established limits. Monitoring extramural days ensures faculty leave balances are accurate and provides good stewardship of the Institution’s benefit expenses.

Recommendation:
Management should ensure compliance with institutional policy regarding extramural leave. The exceptions identified should be corrected in Kronos.

Management’s Action Plan:
Responsible EVP: Thomas Buchholz, M.D.
Owner: Melanie Lopresto
Observer: Wenonah Ecung
Due Date: November 30, 2014

Recently, faculty within this department have become more involved in treating VIP patients overseas and have started to become more engaged in institutional business through the Global Academic Programs and the Cancer Network. We acknowledge that the administrative support team will require additional training to ensure that the appropriate type of leave is requested. This training will occur in the coming months. Additionally, we have identified that the travel plans associated with extramural leave frequently change. Management will implement a procedure with the administrative support staff, including leave report reconciliation, to ensure that a final review is conducted as a routine part of the travel preparations. This will ensure that the time off requested reflects the days that they are actually out of the office.
Observation 4:  
Conflict of Interest Disclosure

The Research Conflict of Interest (COI) Policy (ACA0001) requires host paid travel, as well as honorariums, to be disclosed in the Research COI database. Each faculty member completed their annual disclosure certification timely, as required; however, testing identified 28 confirmed host paid trips and an additional 10 trips that appear to be host paid that were not disclosed.

We also noted that receipt of honorariums or payments are not being consistently disclosed within the Conflict of Interest database.

Disclosure of receipt of travel, honorariums, or other payments assists in ensuring full transparency and reduces the risk that actual or potential conflicts of interest will not be discovered and managed. Undisclosed conflicts of interest jeopardize the objectivity and integrity of research.

Recommendation:
Management should ensure that all faculty are aware of their responsibilities related to disclosure of potential and/or actual conflicts of interest, including honorariums and host paid travel.

Management’s Action Plan:
Responsible EVP: Thomas Buchholz, M.D.
Owner: Melanie Lopresto
Observer: Wenonah Ecung
Due Date: January 31, 2015

The department has consistently ensured that all faculty completed the Conflict of Interest disclosures during the annual certification period. Since we do not have access to the disclosures made, we are not able to review the accuracy of these disclosures. Based upon the observations in this area, we are planning Conflict of Interest training for the faculty to ensure that faculty are aware of which items need to be disclosed.

Observation 5:  
Accounts with Deficit Balances

Management has a fiscal responsibility to monitor departmental accounts to help prevent deficit balances. As of May 2014, the department's Free Balance reports indicate deficits in nine accounts totaling $156,045. These deficit balances ranged from $549 to $93,481. Management is actively working to clear the deficit.

Recommendation:
Management should improve fiscal oversight by monitoring and adjusting spending if necessary to avoid budget deficits. The accounts identified with deficit balances should be cleared.

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Management’s Action Plan:
Responsible EVP: Thomas Buchholz, M.D.
Owner: Melanie Lopresto
Observer: Wenonah Ecung
Due Date: October 31, 2014

Management has taken appropriate action to clear all deficits that were identified as part of this Change in Management Review. These actions are still processing. As a department we have not had adequate resources to obtain regular financial reports. The department has recently secured a financial analyst who is reporting to management the balances on a weekly basis to proactively manage funds and avoid deficits.

Observation 6:
**Grant Reconciliation**

The Grants and Contracts Policy, ADM0122, requires Principal Investigators to monitor the balance of grant funds by reconciling grant accounts monthly. Timely and complete reconciliations act as a detective control to help ensure accurate accounting records.

While the department has implemented controls to approve purchases as they occur, we noted that the grant accounts are not being reconciled. Without reconciling grant accounts, account owners do not know their true available balance and could overspend their account. In addition, financial reports to sponsors, which are based on the accounting records, could be misstated.

Recommendation:
Management should complete reconciliations for all grant accounts on a timely basis and ensure that discrepancies are resolved.

Management’s Action Plan:
Responsible EVP: Ethan Dmitrovsky, M.D.
Owner: Melanie Lopresto
Observer: Maureen Cagley
Due Date: February 28, 2015

Recently, the department has hired a financial analyst who will provide the financial reporting and reconciliation that is required to meet institutional policy. As noted above, management has good controls in place to prevent purchases from inappropriately being charged to grants. We plan to meet with administrators in other departments to identify best practices in grant reporting so that we may implement them in our department.
Observation 7:  
**System User Access**

According to the Information Resources Security Operations Manual, it is the responsibility of the user’s supervisor to make the appropriate modifications to their access upon termination or a role change and periodically monitor the appropriateness of their personnel’s access to Information Resources. During our review of user access, we noted that two terminated employees had active MedAptus (institutional charge capture system) access. The Department has procedures in place to ensure employees are removed from active directory upon departure; however, there is no formal monitoring process to ensure access is terminated for all institutional systems. These procedures are necessary for implementing and maintaining appropriate user access and segregation of duties within the Department’s primary systems. Inappropriate system access may result in errors or irregularities not being detected in a timely manner.

**Recommendation:**
Management should implement controls to ensure user access is granted appropriately and removed timely in accordance with institutional policy. In addition, management should contact Revenue Capture and Support to address the terminated users.

**Management’s Action Plan:**
Responsible EVP: Thomas Buchholz, M.D.
Owner: Melanie Lopresto
Observer: Wenonah Ecung
Due Date: September 30, 2014

This observation was related to a few terminated employees who still had access to MedAptus. The department processes termination JDUFs promptly. When the JDUF is processed, all active directory access is terminated. In addition, the department contacts 4INFO to terminate all access when the Separation Clearance Form is processed. As a result of this finding, we have identified that MedAptus access is not linked to active directory; therefore, management is working with Revenue and Charge Capture support to develop and implement a process to terminate access to MedAptus for employees who leave the institution.

Observation 8:  
**Procurement Card Purchases**

The Department reconciles the procurement card (procard) timely and maintains adequate supporting documentation. However, we noted an instance where the departmental procard was used to procure piano movers for a memorial service held on campus. Institutional procard guidelines prohibit the use of departmental procards for on-site professional services. The cardholder was not aware of the institutional policy; therefore, the moving service did not go through the appropriate vetting process to ensure patient safety.
Recommendation:
Supervisory oversight should be enhanced to ensure compliance with institutional policies for procurement card transactions and that unallowable goods and services are not purchased with the card.

Management's Action Plan:
Responsible EVP: Thomas Buchholz, M.D.
Owner: Melanie Lopresto
Observer: Wenonah Ecung
Due Date: August 31, 2014

This observation is based upon one instance in which a procard was used to pay for a service provided on campus. More specifically, this purchase was related to securing a moving service to move a piano from an adjacent space into the Hickey for a memorial service. This type of procard transaction is atypical for the department and represents a unique circumstance. Management understands and acknowledges the need for services to be secured with a formal purchase requisition. The only procard within the Plastic Surgery is issued to the departmental buyer. This issue was specifically addressed with this individual. Management also approves all purchases including procard purchases. This second level of approval will serve as an additional measure to prevent this from occurring again in the future.
Appendix A

Objective, Scope and Methodology:

The objective of this review was to provide management a general assessment of the financial, administrative, and compliance controls in place within the Department of Plastic Surgery during the period beginning September 2012 through February 2014.

We performed the following procedures:

- Interviewed key personnel to understand administrative processes within the department
- Analyzed leave data for 100% of the Department’s employees to identify employees with unrecorded leave
- Examined documentary evidence to determine if timekeeping and leave management activities are performed within institutional guidelines
- Reviewed expiration dates for licenses and certifications for patient care providers to determine if current or if appropriate notifications were provided
- Conducted internet searches to identify undisclosed conflict of interests
- Reviewed access to institutional systems for 100% of the Department’s employees to determine whether access was appropriately granted based on the employees’ roles and job responsibilities
- Tested procurement card transactions, recordkeeping, and reconciliations for compliance with institutional guidelines
- Reviewed 10 effort cards for the two largest grant awards of the Department to verify the accuracy of effort reporting and the timeliness of certification
- Tested grant expenditures for allowability of costs and progress reports for timeliness
- Reviewed the results of the physical inventory performed by Asset Management
- Traced assets to physical observation
- Reviewed institutional asset records to determine the encryption status of the Department’s IT assets
- Obtained and reviewed information from Clinical Research Finance regarding clinical trial activity in the Department
- Obtained Stat Sampling documentation to validate management approval of review of transactions
- Reviewed Free Balance Reports to identify deficit balances

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