UT Southwestern
Medical Center

**The University of Texas Southwestern Medical Center
Denials Management Audit - MSRDP**

Internal Audit Report 14:10A

November 19, 2014

Executive Summary

Background

Denials management is the process of collecting, tracking, reporting, trending, forecasting, measuring, and managing denied claims. Realized opportunities for enhancing margins have produced the business case for providers to dedicate the necessary resources for denials management as it can be a powerful source for optimizing financial performance.

By analyzing denials, organizations can begin to quantify financial opportunities that may exist through improvements in key revenue cycle processes. For some organizations, as much as 25 percent of all claims are "unclean" (i.e. rejected or denied at some point in the collection process), with at least 5 percent of net revenue being directly affected. A considerable portion of this revenue is lost and never recovered. The vast majority of all denials determined unrecoverable can be prevented with improved controls in upstream processes. Organizations with an effective denials management tracking and classification process should strive for total denials to be less than 3.0% of revenue, with a denial-related bad debt write-off rate of less than 0.5% of revenue. (The Healthcare Financial Management Association establishes the overall bad-debt target to be < 2-3% of revenue). At the time this review was performed, the MSRDP Denial Write-Off Rate as of June 2014 for dates of service June 2013 – May 2014 was reported to be 3.4%. It is important to note that per the June denials report, 73% of the denials experienced are related to services provided at Children's Medical Center and Parkland, whose front-end processes are not under the direct control of the University of Texas Southwestern Medical Center (Medical Center).

An effective denials management program enables healthcare providers to better manage one of their most expensive business risks, resulting in: Identification of key reasons for revenue loss, detailed procedures developed for tracking and appealing denials, more effective and efficient processes, reduced denial volume and improved accounts receivable (A/R), improved patient satisfaction and more integration and enhanced communication between internal departments.

Scope and Objectives

As part of the 2014 Internal Audit Plan, a Denials Management Review was performed for the Medical Center Medical Service, Research, and Development Plan (MSRDP), the group responsible for professional billing and collections for Medical Center physicians. Fieldwork was initiated, performed, and completed during July and August 2014 and consisted of the following primary objectives:

- Review the process for identifying, classifying, tracking and resolving denials[1], including testing of the key control activities to assess the effectiveness of the current process.

- Analyze areas experiencing high levels of denials to determine the effectiveness of front-end processes. Audit selected the Internal Medicine Campus Ambulatory Care area for further review and observed scheduling, registration and benefits verification at the Digestive and Liver Disease Clinic. Additional denials feedback was obtained from other areas including Radiology, Pathology, and Allied Health Physical Therapy.

---

[1] Recovery Audit Contractor (RAC) and other denials resulting from governmental audits are not included within the scope of this review.

Executive Summary

Conclusion

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. See Appendix A for Risk Rating Classifications and Definitions.

High (0)	Medium/High (0)	Medium (5)	Low (2)	Total (7)

The key improvement opportunities noted and risk-ranked as medium are summarized below. Additionally, it should be noted that the MSRDP denials trending and reporting reviewed during this audit is leading practice in many areas compared to similar reporting observed at other physician organizations. In addition, MSRDP leadership meets with each department on a bi-monthly basis to communicate the current A/R status and departmental initiatives that would help reduce A/R and/or denials.
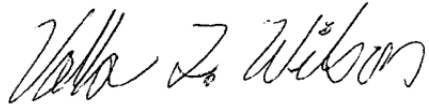
- **Denials Resolution** – Errors existed on denied and zero pay invoices, including untimely or inappropriate follow-up, inaccurate contractual adjustments, payor documentation unavailable in Epic, and insufficient account notes in Epic. Denials resolution deficiencies could result in missed revenue or inaccurate collections reporting.

- **Payment Variance Analysis** – Payments from all contracted payors are not reviewed by Experian and only payments for certain remittance codes are analyzed for contracts reviewed, resulting in a gap in identifying payment variances for those services and contracts not established through the Experian process. Additionally, only underpayments are being identified and reported back to the Medical Center for the contracts set up through the Experian review process (i.e., overpayments are not identified). This could result in a compliance issue, specifically regarding Medicare.

- **Manual Denial Posting Inconsistencies** – Staff members inconsistently apply manual denial codes, which could result in inaccurate reporting and denial routing (delayed revenue).

- **Contractual Adjustment and Write-off Review** – Inaccurate contractual adjustments were applied to four of 15 (27%) of denials tested. In addition, a formal process is not currently in place to monitor/audit the User Batch and Adjustment Posting Reports for two out of four MSRDP departments to ensure denial write-offs and contractual adjustments are appropriate.

- **Department Specific Denials Feedback** – Departmental denials feedback is communicated by MSRDP leadership through departmental denials reports available on the shared "W" drive and bi-monthly departmental meetings to discuss overall A/R performance and any specific concerns regarding increased denials. However, based on discussion with various clinical areas, opportunities exist to ensure this information is provided to all key stakeholders in order to implement processes to reduce future denials.

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

Sincerely,

Valla Wilson, Assistant Vice President for Internal Audit

Audit Team:
Christina Polinski, Senior Consultant, Protiviti
Lauren DeBree, Manager, Protiviti
Landon Adkins, Senior Manager, Protiviti
Tim LaChiusa, Assistant Director of Internal Audit
Richard Williams, Managing Director, Protiviti
Valla Wilson, Assistant Vice President for Internal Audit

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response

Risk Rating: Medium 🟡
 	
1. **Denials Resolution**
 	
Audit identified an error on 10 of15 (67%) denials tested (per the July MSRDP Denials Report). Specific errors include the following:
 	
- Untimely or inappropriate denials follow-up (e.g., not worked within 30 days or not appealed) was noted on 8 of 15 denials tested (53%).
 	
- Inaccurate contractual adjustments were noted on 3 of 15 denials tested (20%).
 	
- A detailed EOB was not available in Epic for 1 of 15 denials tested (7%).
 	
- In general, many account notes were not specific to the cycle in which actions were taken.
 	
Audit identified an error on 15 of 15 (100%) of zero pay invoice line items tested (per the July MSRDP reporting). Specific errors include the following:
 	
- Untimely or inappropriate follow-up (e.g., not worked within 30 days or not refiled/appealed) was noted on 10/15 (67%) invoices tested.
 	
- A detailed Explanation of Benefits (EOB) was not available in Epic for 5 of 15 invoices tested (33%).
	1. Review the examples provided to determine the process break-down that occurred. Determine the need for any additional monitoring to ensure denials follow-up is appropriate and timely to prevent revenue leakage.
	
	2. Continue the established Quality Assurance (QA) program for each staff member on a monthly basis to identify specific team members requiring additional training.
	
	3. Reinforce the requirements for timely and appropriate follow-up through existing process flows and staff enrichment training activities.
	
	4. Document and provide to staff account note documentation standards to ensure accounts with multiple invoices (cycles) clearly identify all information related to the specific encounter being worked, (e.g., date of service and charge being referenced).
		Action Plan Owners:
		
		Assistant Director, Physicians Insurance Collections
		
		Target Completion Date:
		
		1. December 31, 2014
		
		2. Complete
		
		3. December 31, 2014
		
		4. December 31, 2014
		
		Management Action Plan:
		
		1. Management is currently assessing total work queue volume to determine appropriate staffing needs to ensure timely and accurate follow-up occurs. The methodology (report) used to support additional staffing needs has a target completion date of December 31, 2014.
		
		   a. Staffing results will be presented to Senior Management for review/approval.
		
		   b. Once approved – MSRDP will begin actively recruiting for the additional positions.
		
		2. Management will continue addressing training opportunities identified through the monthly QA Process. Additional classroom training was performed in September 2014 on specific items identified through the QA process. Additionally, management will host continuing education classroom training to staff quarterly. Topics will be determined based on potential QA errors noted during the previous months.
		
		3. Supervisors and managers are reviewing work queue inventory weekly to prioritize items requiring follow-up. The department is also

Observation	Recommendation	Management Response
		currently working with Finance to create management reports that will identify aging on the active tab. Essentially, this management tool will list invoices appearing on the active tab within the work queue that requires follow up based on the number of days the item have been on the active tab. The target completion date for this initiative is December 31, 2014. The leadership team is currently working with staff to revise/modify daily work flows to ensure most recent changes have been incorporated with a target completion date of December 31, 2014. 4. Management will schedule additional classroom training to all follow up staff to reinforce the current process of appropriately documenting Account Notes. Once training is complete, the process will be monitored through the monthly QA process.
Risk Rating: Medium ⬤ 2. **Payment Variance Analysis** Gaps exist within the MSRDP Billing Operations department and third party (i.e., Experian) Contract Management process in regards to identifying and resolving contractual payment variances (i.e., over/underpayments) that do not result from a denial identified on the remittance advice (RA). Payments from all contracted payors are not reviewed by Experian (specifically, low volume contracts are not set up through the Experian process), and only payments for certain remittance codes are analyzed for contracts reviewed. This results in a gap in identifying payment variances for those services and contracts not established through the Experian process.	1. Review the complete list of contracts and remittance codes Experian is reviewing at least annually and consider whether additional contracts and/or remittance codes should be added to or removed from Experian's process based on a cost/benefit analysis. Monitor payor and procedure volumes throughout the year and add payors and procedures to the Experian payment variance process as volumes warrant inclusion. 2. Begin receiving overpayment reports from Experian for Medicare claims (at a minimum) to ensure compliance with Medicare Conditions of Participation. Assess whether Experian should identify overpayments based on specific payor contract	**Action Plan Owner:** Associate Vice President for Faculty Practice Patient Financial Services Associate Director for Practice Plan Information Resources **Target Completion Date:** 1-3. December 31, 2014 **Management Action Plan:** 1. On an annual basis, we will begin reviewing all payor contracts and associated revenue and will consider adding any payor contract whose revenue is 5% or greater to Experian's payment review process. As part of this review, we will also assess the remittance

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Additionally, only underpayments are being identified and reported back to the Medical Center for the contracts set up through the Experian review process (i.e., overpayments are not identified). This could result in a compliance issue, specifically regarding Medicare. For commercial payors, this could be a concern if the Medical Center has a contractual requirement to report overpayments. (Please note, audit procedures did not include a review of specific contracts, and therefore Audit cannot comment further on specific Medical Center contractual requirements). Please note, Collections staff does verify payment accuracy by comparing the payment to the fee schedule in instances of partially paid invoices.	requirements for all other payors included in the Experian underpayment review process. Include overpayment identification to the Experian process as contractually obligated. 3. Implement a process to periodically review at least a sample of payments received for contracts not reviewed by Experian to ensure payment accuracy.	codes that are currently being reviewed by Experian and make a strategic decision regarding adding/removing additional codes to/from their review. The first review will occur by December 31, 2014. 2. In addition, we will begin actively reviewing Epic overpayment reports (at least for Medicare) to ensure Medicare overpayments are identified. The first report will be generated and reviewed by December 31, 2014. 3. We will perform a high level review of Epic payment variance reports for managed care payors not reviewed through the Experian process on a monthly basis. The first review will occur by December 31, 2014.
Risk Rating: Medium 🟡 3. **Manual Denial Posting Inconsistencies** Through testing and observation, Audit noted staff members inconsistently applying manual denial codes. Testing identified the incorrect denial code reported per the EOB for 1 of 14 (7%) denials tested. Through observation, two staff members utilized code 16 (additional info needed) rather than using the information in the denial letter to post a specific denials code. Examples where code 16 was used instead of a more specific code include newborn enrollment and no record of coverage for the group/ID number. Accounts are routed to the appropriate work queue based on the remittance codes entered. Entering a general denials code (rather than a specific denials code) could result in inaccurate reporting and the denial being routed to an inappropriate work queue, leading to A/R delays.	1. Define and communicate the expected process for posting manual denials (including using the information contained in the denials letter to provide a specific denials code) to the appropriate departmental personnel. Provide regular feedback to posting staff when inconsistent practices are identified (e.g., accounts are consistently ending up in the wrong work queue, etc.) or when other opportunities for improvement are identified.	**Action Plan Owner:** Assistant Director, Physician Billing/Collections/Support **Target Completion Date:** 1. Complete **Management Action Plan:** 1. We have recently implemented a training program to ensure manual denials are posted in a way that is consistent and accurate across staff. In addition, we have implemented a quality assurance program, consisting of a review of several accounts worked by each staff member each month. Feedback from this review will be provided to each staff member through individual monthly evaluations and training opportunities presented to the entire department as needed. The first round of feedback from this review will be provided to

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
		staff by September 30, 2014.
Risk Rating: Medium 🟡 4. **Contractual Adjustment and Write-off Review** Testing of denied accounts identified inaccurate contractual adjustments applied to 4 of 15 (27%) of denials tested. In addition, a formal process is not currently in place to monitor/audit the User Batch and Adjustment Posting Reports for two of four MSRDP departments to ensure denial write-offs and contractual adjustments are appropriate. Some MSRDP departments are reviewing this report from time to time, but not on a pre-defined/consistent basis according to pre-defined criteria. In addition, evidence of this review is not maintained. It is important to note the Follow-Up and Cash Posting teams have a standard monthly quality assurance (QA) review for each staff member, which includes a review of contractual adjustments and write-offs. In addition, the Adjustments Team is in the process of implementing a work-queue where credits can be reviewed (in response to the Internal Audit Credit Balance Review recently completed).	1. Implement a standard review of a predefined number of adjustments weekly to ensure the sampled accounts were adjudicated appropriately and the adjustments applied by the staff are appropriate. Though this review may focus on higher dollar adjustments for the most part, it should also include some lower dollar adjustments to ensure they are also being applied appropriately. Implement a standard denial write-off review for a specific number of denial write-offs each month to ensure the account was adjudicated appropriately and the write-offs applied by the staff are appropriate. This should include a write-off adjustment review by account to identify any users bypassing system controls and making multiple adjustments less than their designated threshold.	**Action Plan Owner:** Assistant Director, Physician Billing/Collections/Support Manager, MSRDP Account Services **Target Completion Date:** 1. Complete **Management Action Plan:** 1. We will create a formal adjustment and write-off QA review process to be performed monthly. Attributes noted in the recommendation will be included in the QA review process. The formal QA process will be in place by October 30, 2014.
Risk Rating: Medium 🟡 5. **Clinic Specific Denials Feedback** Departmental denials feedback is communicated by MSRDP leadership through departmental denials reports available on the shared "W" drive and bi-monthly departmental meetings to discuss overall A/R performance and any specific concerns regarding increased denials. However, based on discussion with various clinical areas, opportunities exist to ensure this information is provided to all key stakeholders in order to implement processes to	1. Work with the departments who believe their denials data is not complete to confirm whether or not the denials reports are adequately capturing all relevant information and seek feedback on how the reports can be improved. 2. Ensure all Medical Center clinics and departments are aware of the denials reports available to them. Request feedback from all clinics and departments to assess their awareness and understanding of the denials reports available to them.	**Action Plan Owner:** Associate Vice President for Faculty Practice Patient Financial Services Assistant Director, Physicians Insurance Collections Associate Vice President, Chief Administrative Officer, Aston Ambulatory Center **Target Completion Date:** 1a. Complete 1b. December 31, 2014

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
reduce future denials. • Per discussion with the Internal Medicine Digestive and Liver Disease Clinic and the Allied Health Physical Therapy clinic, these departments do not receive or are not aware of denials feedback related to their clinics. Additionally, Allied Health Physical Therapy believed their denial report was incomplete after Internal Audit shared a copy with them. • Per discussion with the Pathology department, they are aware of the denials information published on the shared "W" drive but do not believe it to be complete. In addition, they claimed it was not detailed enough for them to adequately research problems at the encounter level. As a result, they currently compile their own denial analysis data using programs such as SQL and Microsoft Access.	3. Continually train departments and incoming departmental staff on how to look at and understand the denials data within each of the denials reports and provide summary data where appropriate. 4. Update denials reports as needed to better serve the needs of the departmental staff.	2. December 31, 2014 3. Complete 4. December 31, 2014 **Management Action Plan:** 1a. The Finance reporting for Pathology is the exception to the other departments due to the size of the database for their respective claims. For the most part, Pathology reports must be rolled up to a higher level due to MSOffice limitations. However, the department is provided with a detailed database via SQL server, plus an Accounts Receivable file to the transaction/denial level. We will work with Pathology to determine their needs. Initial discussions will take place by December 31, 2014. 1b. Finance has QA processes to ensure all denials are reported as represented in Epic. We welcome the opportunity to meet with departments to better understand their concerns. We will reach out to Allied Health Physical Therapy regarding their concerns by December 31, 2014. 2. All Finance W drive reports are made available to Departmental Billing Managers plus key departmental staff, including divisional people responsible for working denial issues. Department Billing Managers are responsible for allowing visibility to the respective reports by authorizing access to secure departmental directories. In our next round of bi-monthly meetings with the Department Billing Managers, we will discuss the extent of denials feedback that is currently provided to Clinic Managers and encourage the

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
		Department Managers to routinely communicate with the Clinic Managers, specifically regarding denials feedback applicable to the clinic processes. These meetings will take place by December 31, 2014.
		3. Finance has been conducting report training classes over the summer, which will be continued over the next year. Anyone who would like to attend is welcome. We will communicate this to Department Managers in the next bi-monthly meetings who in turn can communicate it to their respective Clinic Managers if they choose to. These meetings will take place by October 31, 2014.
		4. We will add the top clinic denials to the front-end dashboards that Clinic Managers currently have access to in Epic. In addition, we will create folders at the clinic level for their specific denials detail. This will be added by December 31, 2014.
Risk Rating: Low ● 6. **Standard Denials Reporting/Benchmarks** The "collection rate" and the "denial rate" utilized within the MSRDP denial report are not calculated according to standard industry practice. However, this report is utilized as a management tool and the calculations allow Management to adequately monitor collections and denials write-offs. Opportunities exist to expand the denials reporting to include key metrics and to benchmark key denials statistics against other physician organizations. Testing of denials identified in the July MSRDP Denials Report identified 3 of 15 (20%) denials where the payor documented in the denials report	1. Further refine the definitions of each calculation within the existing denials report to clearly communicate the metric being measured. 2. Develop additional denials reporting based on industry specific best practice metrics, in order to benchmark denials information and performance against other physician organizations. For instance, three metrics that can provide a quick overall baseline of the denials management process include the overall initial denials rate, denials overturned by appeal rate, and overall denials write-off rate. We recommend a leading practice overall	**Action Plan Owner:** Associate Vice President for Faculty Practice Patient Financial Services Manager, MSRDP Financial Affairs Manager, MSRDP Financial Affairs **Target Completion Date:** 1. Complete 2. December 31, 2014 3. December 31, 2014 **Management Action Plan:** 1. On the definitions tab within the denials report, we will clearly define what each key metric is

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
does not match the payor from whom the denial was received. In addition, testing of zero pay transactions from July 2014 not included in denials reporting identified 4 of 15 (27%) line items with a denial on the remittance advice not included in the denials report. This could mean denials reporting is incomplete. In addition, data fields available for specific line item denials vary by department when drilling into denials detail. For example, denials related to Pathology did not include the date of service denied, making it difficult to pinpoint the specific line item denied.	initial denials rate for physician practices to be less than 2%, which is further supported by professional organizations such as Healthcare Financial Management Association (HFMA). HFMA defines the overall initial denials rate to be less than 2% for physician practices. HFMA also establishes the denials overturned by appeal rate as 40% - 60%. In addition, we've seen best practice organizations able to achieve an overall denials write-off rate less than 0.5% on a consistent basis (HFMA defines the overall bad-debt target to be less than 2-3%). 3. Review the zero pay examples identified with denials not reported to determine if there is certain logic that can be updated to ensure all denials information is included within available reporting. Review data fields available for the Pathology department to determine if additional information would be available for reporting.	calculating. This will be updated by September 30, 2014. 2. We will review and research the testing exceptions noted in order to identify root cause issues and develop appropriate remediation action plans. The initial review of the testing exceptions will be completed by December 31, 2014. 3. The Medical Center has recently partnered with UHC – University Healthcare Consortium to share pertinent financial statistics, including denial metrics, across all memberships. This will allow us to compare our denial data to other physician organizations. This will be in place by December 31, 2014.
Risk Rating: Low 🟢 7. **Process Efficiency Opportunity** Through observation, Audit noted large quantities of paper were routinely printed and manually filed specifically within the non-electronic remittance and zero pay posting processes. As part of this process, employees balance the batch, print the batch proof report and reconciliation, and complete a brown envelope as evidence of the batch posting and batch totals. However, this step is not necessary as the batch proofs are already stored in Epic.	1. Eliminate the process of manually filing paper copies of the batch proof report since they are already stored in Epic. Look for additional opportunities for other processes where similar information may already be stored in Epic or on a shared drive that is routinely backed up to reduce paper filing based on storage costs and the time-intensive labor efforts associated with manual filing.	**Action Plan Owner:** Assistant Director, Physician Billing/Collections/Support Manager, MSRDP Billing Operations **Target Completion Date:** 1. Complete **Management Action Plan:** 1. We agree with the recommendation noted. This will be completed by September 30, 2014.

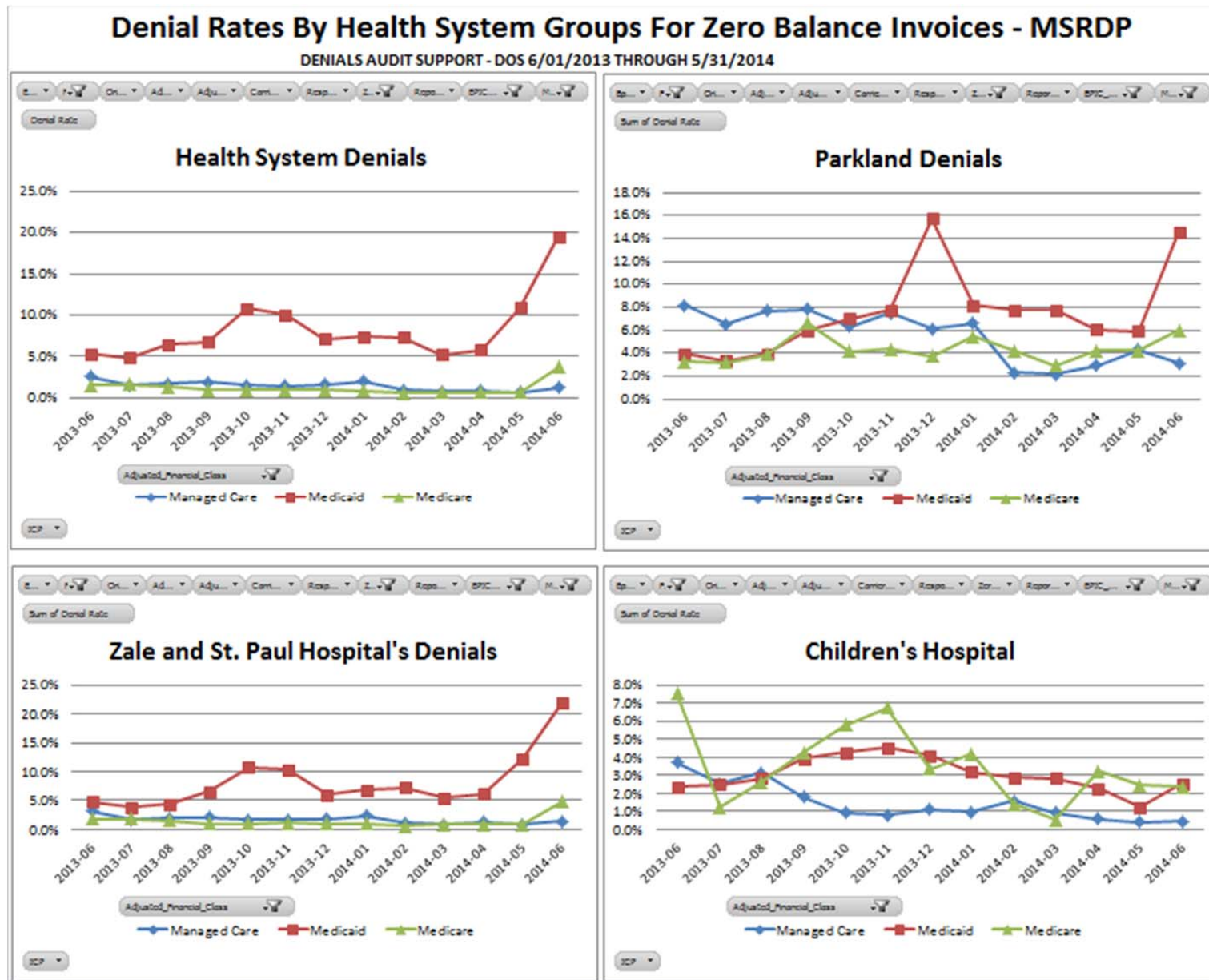# Appendix A – Risk Classifications and Definitions

As you review each observation within the Detailed Observations and Action Plans Matrix of this report, please note that we have included a color-coded depiction as to the perceived degree of risk represented by each of the observations identified during our review. The following chart is intended to provide information with respect to the applicable definitions and terms utilized as part of our risk ranking process:

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.	Degree of Risk and Priority of Action	
	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.
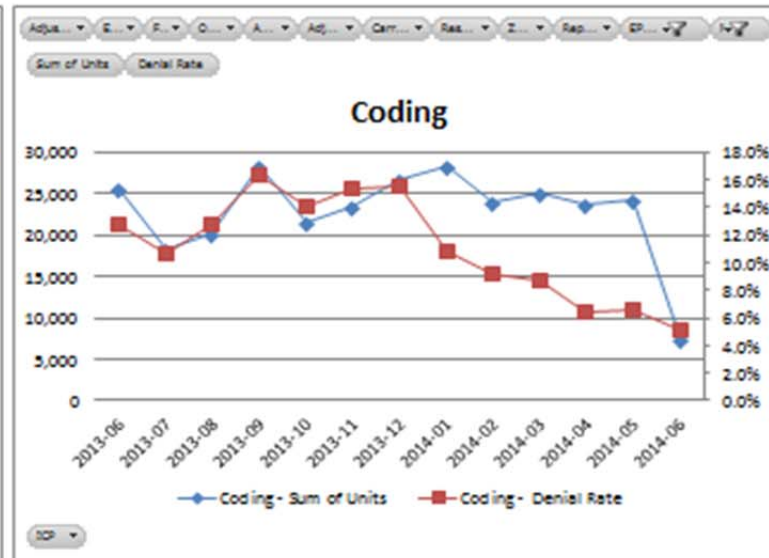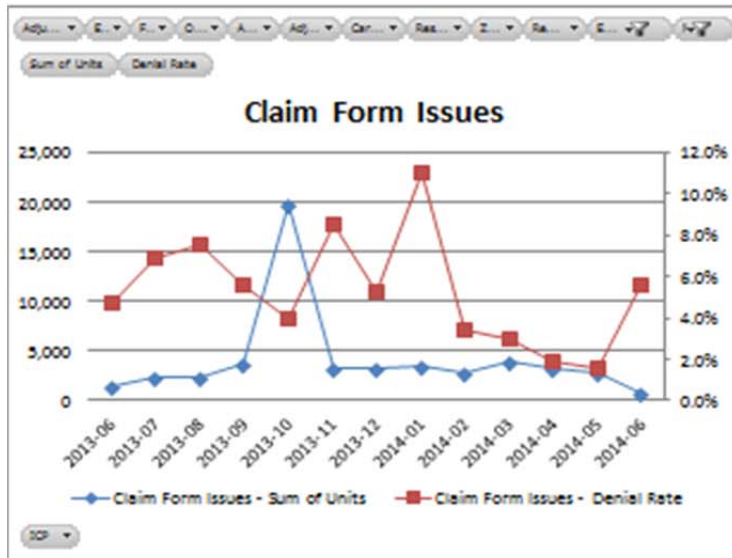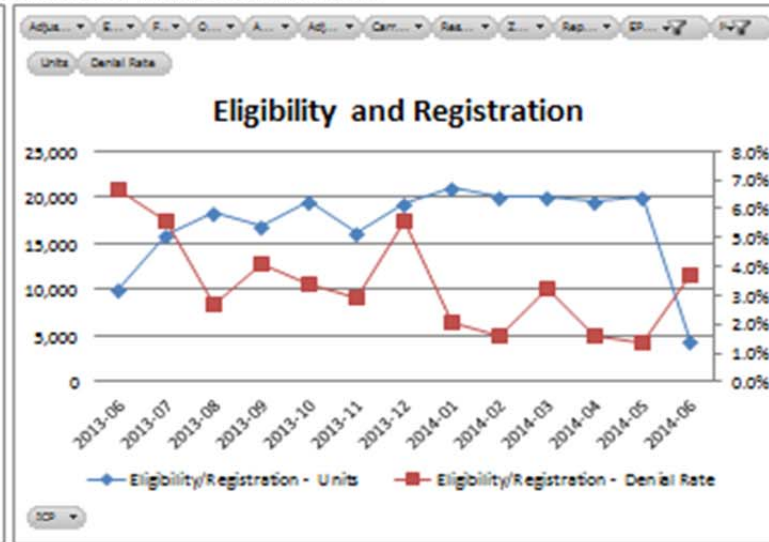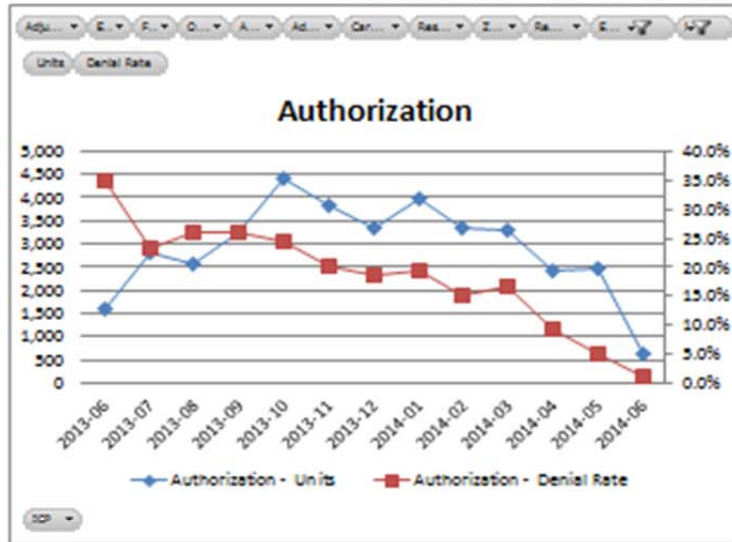
Appendix B – Denials Data

Denial Rates By Health System Groups For Zero Balance Invoices - MSRDP

DENIALS AUDIT SUPPORT - DOS 6/01/2013 THROUGH 5/31/2014

Appendix B – Denials Data

Denial Rates By Remit Category 1 - Collection Analysis - MSRDP

DENIALS AUDIT SUPPORT - DOS 6/01/2013 THROUGH 5/31/2014

Appendix B – Denials Data

Denial Rates By Remit Category 1 - Collection Analysis - MSRDP

Excludes the Most Recent 2 Months to Allow For Adjudication Time