Office of Internal Audit

UT Southwestern
Medical Center

The University of Texas Southwestern Medical Center
Revenue Cycle Customer Service Operations Audit

Internal Audit Report 16:07

September 23, 2016

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Executive Summary

Background

Within the UT Southwestern Revenue Cycle department, customer service is provided to the patient community by the Account Resolution department. The department was recently formed in January 2016 as a part of the UT Southwestern Health System Affairs Single Billing Office initiative (SBO). This initiative was designed to improve the level of support provided to the hospital and clinic patients and facilitate more efficient cohesive patient services. With the SBO, patients receive one monthly statement that includes all Medical Center physician, clinic, or hospital services provided in multiple locations such as a hospital, clinic, laboratory, or imaging center. This single statement reflects all services received including clinic appointment, lab test, procedure, or extended hospital stay. Patient inquiries regarding statements come into this centralized group rather than calls being split between different hospital and clinic practice functions as previously done.

The Account Resolution department is composed of 28 Customer Account Analysts (CAA) and Financial Advocates (FA) and addresses patient questions, concerns and complaints. The department often coordinates with other Revenue Cycle functions and various University Hospitals and MSRDP departments, as needed, to fully resolve the patient inquiries and complaints. The Epic system is used to review patient account activity, evaluate patient inquiries and document actions taken. Epic work queues are used to track outstanding patient requests. The OpenScape automated phone system is a customer service management tool used to track call volumes, types of calls received from patients as well as record calls for quality review and training.

Appendices B and C presents graphical summaries of key data related to the Account Resolution department including call volumes, call types and Epic work queue activity.

Objectives and Scope

This audit was risk based and scheduled as a part of our Fiscal Year 2016 Audit Plan. The audit focused primarily on the management of customer service inquiries, requests and complaints including adequacy of evaluation of each patient's request and timely response to patients, and resolution of issues.

The audit scope period was September 2015 through May 2016. Audit procedures included: interviews with the Account Resolution team members and Revenue Cycle leaders, walkthroughs, review of policies and procedures and other documentation; and analysis and testing of monthly activity reports and related work queues.

General objectives of the Customer Service Operations audit have been established in accordance with our Internal Audit Charter and include:

- Determine the adequacy and effectiveness of process, oversight, and monitoring controls in place to ensure
    - Timely and effective response to customer needs
    - Authorized and accurate adjustments to patient accounts
- Assess appropriateness of related Epic system controls. This assessment will be included in a separate Audit report.

Executive Summary

We conducted our examination according to guidelines set forth by the Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing.

Conclusion

Overall, the recently formed Account Resolution Department is developing and maturing and complies with UTSW policies and procedures. There are opportunities to increase functional maturity in several areas: the root cause of patient inquiries should be identified and action plans developed to reduce the overall number of calls into the department and detailed reports are needed to ensure timely management of patient accounts.

The OpenScape customer service management tool recently implemented is an important tool for the department and provides the team with data for monitoring key metrics.

The table below summarizes the observations and the respective disposition of these observations in the UT Southwestern internal audit risk definition and classification process. See Appendix A for Risk Rating Classifications and Definitions.

There were no Priority risk issues identified in the audit. Key improvement opportunities risk-ranked as High and Medium are summarized below.

Priority (0)	High (0)	Medium (3)	Low (2)	Total (5)

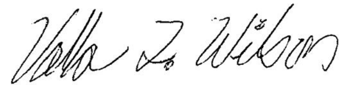
- **Develop Action Plans to Address Root Cause of Patient Inquiries –**The root cause of patient inquiries should be identified and action plans developed to reduce the overall calls received from patients, increase collections and increase patient satisfaction.
- **Enhance Management Reporting to Monitor Service Levels Within the Account Resolution Department –** Monitoring of key department activities should be enhanced to track and monitor patient call backs and inquiries to final resolution. Defined service levels are not being met due to lack of effective management reporting and greater than anticipated call volume
- **Increase Timeliness of Resolution of Accounts in Hold Work Queues** – 1,666 patient accounts were in several "Hold" work queues (WQs) in the Epic system preventing billing statements from being mailed to the patient.

Management has implemented or is in the process of implementing corrective action plans. Management responses are presented in the Detailed Observations and Action Plans Matrix (Matrix) section of this report.

We would like to thank the Revenue Cycle teams, specifically the Account Resolution team, for their assistance and cooperation during this review.

Executive Summary

Sincerely,



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Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium	Identify the root cause for the primary types of patient inquiries and develop detailed action plans to address and reduce call volumes going forward and increase patient satisfaction.	**Management Action Plans:**

Observation

Risk Rating: Medium

1. Develop Action Plans to Address Root Cause of Patient Inquiries

While primary reasons for patient inquiries are identified (see table and graph below), the root cause by type has not been fully analyzed to determine action plans that could be put into place to reduce the overall number of calls.

Development of action plans will help to ensure more efficient use of resources, increase in collections and increase in patient satisfaction. Input and coordination from all Revenue Cycle departments as well as specialty departments will be needed in the development of these plans.

With call volumes increasing, additional resources may be needed if action plans are not implemented. Calls from patients have increased 11% since December 2015, due primarily to insourcing of hospital self-pay collections. The abandoned call rate has increased more than 60% since December 2015.

Average Monthly Calls	Monthly Received	Monthly Abandoned
Oct 15 - Dec 15	11,975	1,165
Jan 16 - May 16	13,268	1,944
Period over Period Increase	11%	67%

Recommendation

Identify the root cause for the primary types of patient inquiries and develop detailed action plans to address and reduce call volumes going forward and increase patient satisfaction.

Management Response

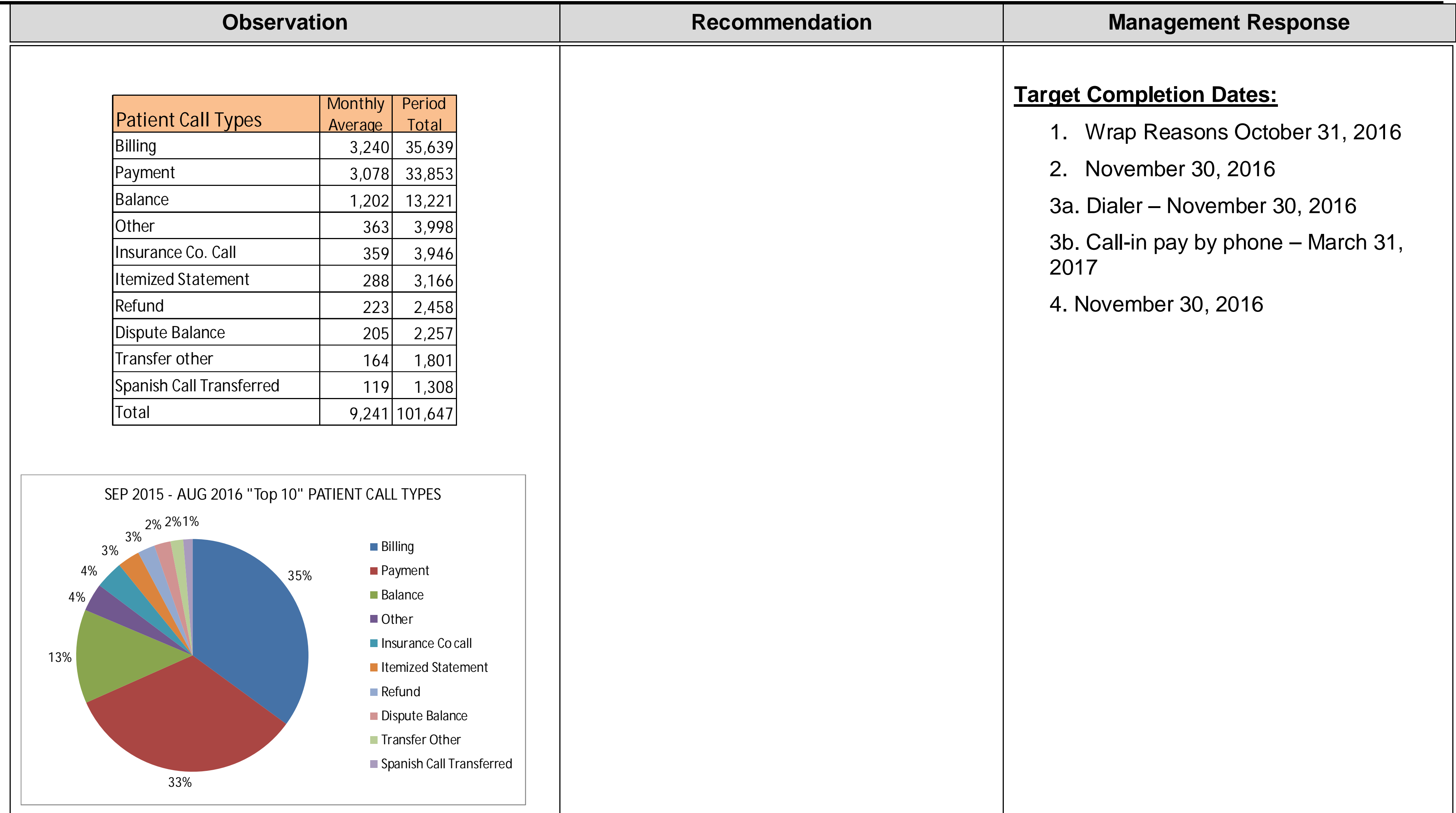
Management Action Plans:

1. We will be adding more detailed wrap reasons, to more effectively identify purpose of call.
2. For billing call types, we will analyze the details within the wrap reasons and develop plans to reduce the overall number of calls.
3. For payment call types,
    a. An automated dialer will be implemented to request payments from patients
    b. A call-in pay by phone feature will be implemented so patients can make a payment without the need to talk to the Customer Service team
4. For the Insurance Company calls, the contact information will be changed to direct companies directly to the Follow Up team.

Action Plan Owners:

Manager, Account Resolution

Detailed Observations and Action Plans Matrix



Observation	Recommendation	Management Response

Patient Call Types	Monthly Average	Period Total
Billing	3,240	35,639
Payment	3,078	33,853
Balance	1,202	13,221
Other	363	3,998
Insurance Co. Call	359	3,946
Itemized Statement	288	3,166
Refund	223	2,458
Dispute Balance	205	2,257
Transfer other	164	1,801
Spanish Call Transferred	119	1,308
Total	9,241	101,647

Target Completion Dates:

1. Wrap Reasons October 31, 2016
2. November 30, 2016

3a. Dialer – November 30, 2016

3b. Call-in pay by phone – March 31, 2017

4. November 30, 2016

Detailed Observations and Action Plans Matrix

<table>
<tr><th>Observation</th><th>Recommendation</th><th>Management Response</th></tr>
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Risk Rating: Medium
2. Enhance Management Reporting to Monitor Service Levels Within the Account Resolution Department
Service level indicators have been defined for the function, however, defined service levels are not being met due to lack of effective management reporting and greater than anticipated call volume.
The following service level deficiencies were identified:
• 24 Hour Response Time - Analysis of key work queues indicated 43% did not receive a return call from a CAA within the established 24-hour standard response time.
• 48 Hour Response Time - Analysis of 12 FA work queues indicated 21 of 24 accounts (88%) were never reviewed or reviewed in excess of the 48-hour standard response time.
• Voicemail Requests - Analysis of 15 voicemails from patients showed 12 of 15 patients (80%) did not receive a return call from the CAA within the standard 24-hour response time. Five of those calls were from patients stating they wanted to make a payment.
• Email Requests - Analysis of emailed inquiries from patients in the Patient E-mailbox in June 2016 showed none were reviewed by a CAA or FA within the 24-hour response standard.
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1. Develop escalation procedures for overdue and outstanding requests from other departments, including monthly status reporting.
2. Coordinate with Health System Information Resources and Enterprise Data Services to design and implement additional operational reports to identify gaps in service level expectations. Suggestions include:
• Accounts in WQs without Ticklers
• Aging of accounts across all WQs including dates last worked
• Accounts in work queues from emails and voice messages exceeding standard response times
3. Implement Customer Survey feedback tools and define how the surveys will be tracked, evaluated and used as a training opportunity for staff to promote effective customer service throughout the department.
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<u>Management Action Plans:</u>
1. Define escalation processes to include billing manager, department administrators and others as needed to ensure timely response is received.
2. Continue to work with IR to finalize operational reports
3. Customer surveys using the telecom system will be developed and results monitored monthly.
<u>Action Plan Owners:</u>
Manager, Account Resolution
<u>Target Completion Dates:</u>
1. November 30, 2016
2. December 31, 2016
3. March 31, 2017
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Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
• Outstanding Patient Requests – A tickler system within Epic is used to set reminders for CAA and FA staff to remind them to return a patient call or take other action. However, the use of the tickler system is infrequent. Analysis of the top 19 WQs ($1.74M) showed 1,289 accounts with only 76 ticklers. Finally, patient complaint feedback tools such as oral telephone and/or written customer satisfaction surveys are not in use. Implementing patient feedback will aid in improving customer service.		

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium		

3. Increase Timeliness of Resolution of Accounts in Hold Work Queues

At the time of audit, 1,666 patient accounts were in several "Hold" work queues (WQs) in the Epic system to prevent billing statements from being mailed to the patient until various errors are corrected. When statements are not sent, the patients are not aware of the status of their accounts resulting in delayed collections and increased patient dissatisfaction.

An aging analysis of these 1,666 accounts showed the 46% were older than 30 days as follows:

Age (Days)	Quantity	Percentage
0 – 30	908	54%
30 – 60	381	23%
60 – 90	271	16%
90 – 120	80	5%
120 or more	26	2%

Further root cause analysis of the accounts older than 120 days indicated that 61% were on hold waiting on other departments for additional information to resolve the account issues. These accounts were not tracked and departments were not held accountable for providing information to properly resolve the accounts,

Recommendation

1. Coordinate with Health System Information Resources and Enterprise Data Services to design and implement an aging report for the Hold WQ, to summarize how long an account has been in a waiting state.
2. Take proactive steps to resolve root cause of accounts in Hold status, including coordination with other departments as needed to obtain needed information.

Management Response

Management Action Plans:

1. Work with IR to develop aging report for items within the Hold work queue.

2. Develop procedures to resolve accounts in Hold status, including coordination with the Patient Assistance Office or others. Also, weekly meetings will be scheduled to monitor the status of accounts in Hold status.

Action Plan Owners:

Manager, Account Resolution

Target Completion Dates:

1. November 30, 2016

2a. Document procedures – November 30, 2016.

2b. Resolution of accounts in Hold status – March 31, 2017

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Low ● **4. Implement a Quality Assurance Program** Development of a quality assurance program will assist the Account Resolution team in meeting their goals of providing efficient and timely resolution of patient inquiries. In coordination with the Account Resolution leaders, a sample of recorded calls were tested for several attributes of effective customer service, such as: o Balance business need with patient need; o Effective listening; o Whether a payment was obtained; and, o Overall call Pass / Fail The results of this assessment were: - 44% of the calls failed one or more of the attributes for effective customer service. - 73% of inquiries were not fully resolved and required additional attention by Account Resolution staff or other Revenue Cycle departments for resolution.	Develop a quality assurance program incorporating key customer service elements, routine review and assessment of team members and action plans to improve overall results.	**Management Action Plans:** Implemented quality assurance program in June. Next step is to develop action plans to address opportunities identified. **Action Plan Owners:** Manager, Account Resolution **Target Completion Dates:** November 30, 2016

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Low ● **5. Develop Staff Training Programs** Ongoing training plans are not in place to ensure Account Resolution department staff continue development of the requisite skillsets required to efficiently address patient inquiries with more accurate information, more quickly complete phone calls, and obtain greater professional expertise. In addition, supervisors do not consistently meet with staff for individual coaching sessions. The CAA and FA staff role requires a specialized skillset including knowledge of accounting and billing processes; insurance benefit plans, claims, denials, workers' compensation, charity rules; payment plans; refund processes; poise under pressure; and interpersonal skills. Continuing training in these skills should be developed to enhance department productivity and patient satisfaction. In addition, as illustrated in Appendix C, patient talk time duration and patient call wait time duration is increasing indicating increased inefficiency which can result in patient dissatisfaction. Account Resolution management expects Supervisors to conduct weekly one-on-one coaching sessions with staff. However, testing revealed nine staff never met with their Supervisor for a coaching session during the scope period and one Supervisor did not have conduct coaching sessions from October through December 2015 and another did not conduct meetings with their staff from February through May 2016.	1. Create a Master Skills List of all subject areas a seasoned UTSW CAA and FA should know thoroughly to be highly effective in their role. This list should be comprised of technical skills and "soft" (interpersonal) job skills. a. Define the UTSW Account Resolution department function roles and responsibilities with measureable success criteria. b. Define the role of the Account Resolution Customer Account Analyst and Financial Advocate and identify how their success is measured. 2. Based on the Master Skills List, evaluate each experienced CAA and FA staff member and create individualized training plans. 3. Reemphasize expectations regarding Supervisor weekly staff development sessions and implement reporting tools such as a status memorandum to ensure these coaching sessions are held consistently.	**Management Action Plans:** 1. Master Skills List will be developed and key roles and responsibilities defined. 2. Team will be evaluated against the Master Skills List and individual training plans developed. 3. Supervisors will meet weekly with team members for staff development sessions. **Action Plan Owners:** Manager, Account Resolution **Target Completion Dates:** 1. November 30, 2016 2. November 30, 2016 3. Completed

UTSouthwestern Medical Center

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:

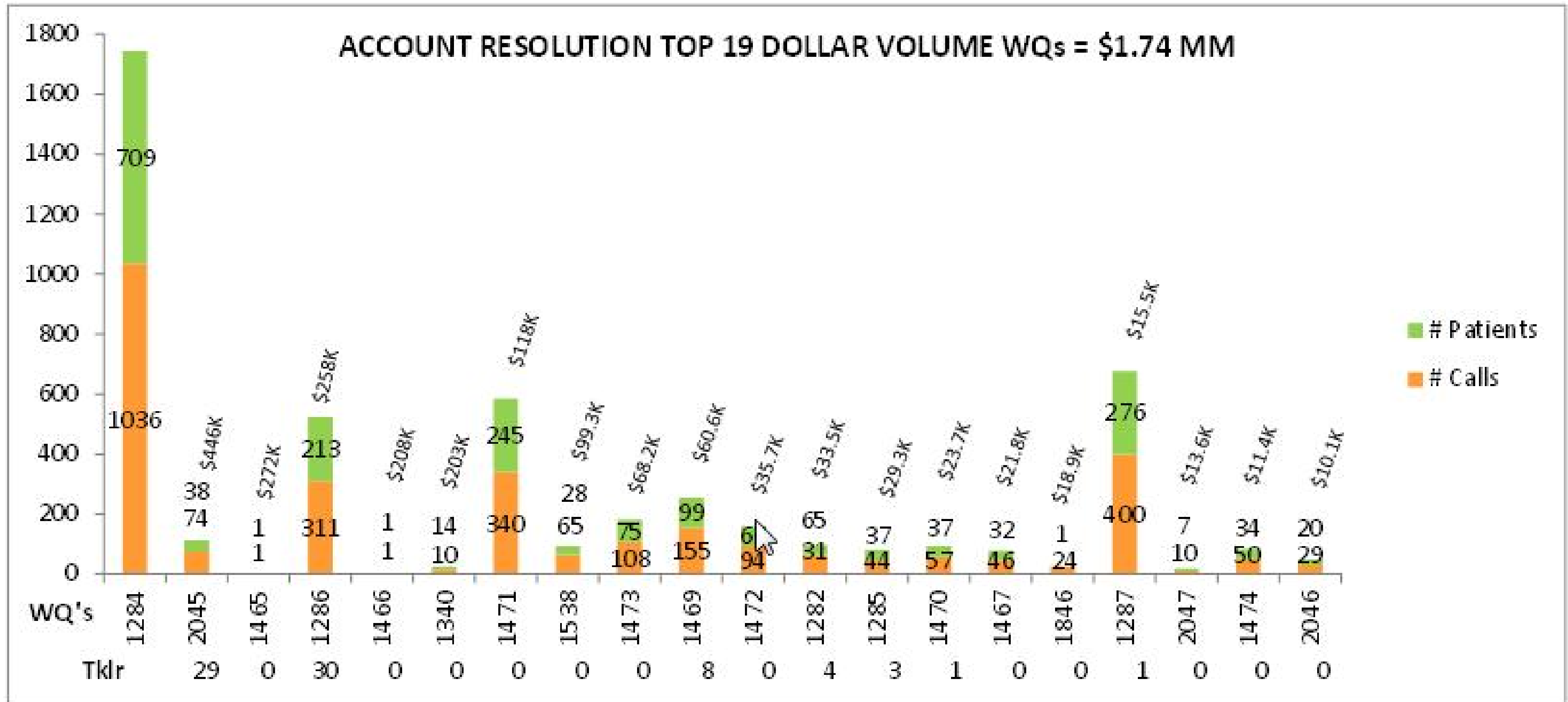
Risk Definition	Degree of Risk and Priority of Action	
Risk Definition - The degree of risk that exists based upon the identified deficiency combined with the subsequent priority of action to be undertaken by management.	**Priority**	An issue identified by internal audit that, if not addressed immediately, has a high probability to directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole.
	High	A finding identified by internal audit that is considered to have a high probability of adverse effects to the UT institution either as a whole or to a significant college/school/unit level. As such, immediate action is required by management in order to address the noted concern and reduce risks to the organization.
	Medium	A finding identified by internal audit that is considered to have a medium probability of adverse effects to the UT institution either as a whole or to a college/ school/unit level. As such, action is needed by management in order to address the noted concern and reduce risk to a more desirable level.
	Low	A finding identified by internal audit that is considered to have minimal probability of adverse effects to the UT institution either as a whole or to a college/ school/unit level. As such, action should be taken by management to address the noted concern and reduce risks to the organization.

It is important to note that considerable professional judgment is required in determining the overall ratings presented on the preceding 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 – Key Graphic Summaries

The graph below illustrates the dollar volume and call volume related to each Epic work queue managed by the Account Resolution team.



Appendix B – Key Graphic Summaries

The below graphs illustrate the volume of calls by call type for the scope period.

Patient Call Types	Monthly Average	Period Total
Billing	3,240	35,639
Payment	3,078	33,853
Balance	1,202	13,221
Other	363	3,998
Insurance Co. Call	359	3,946
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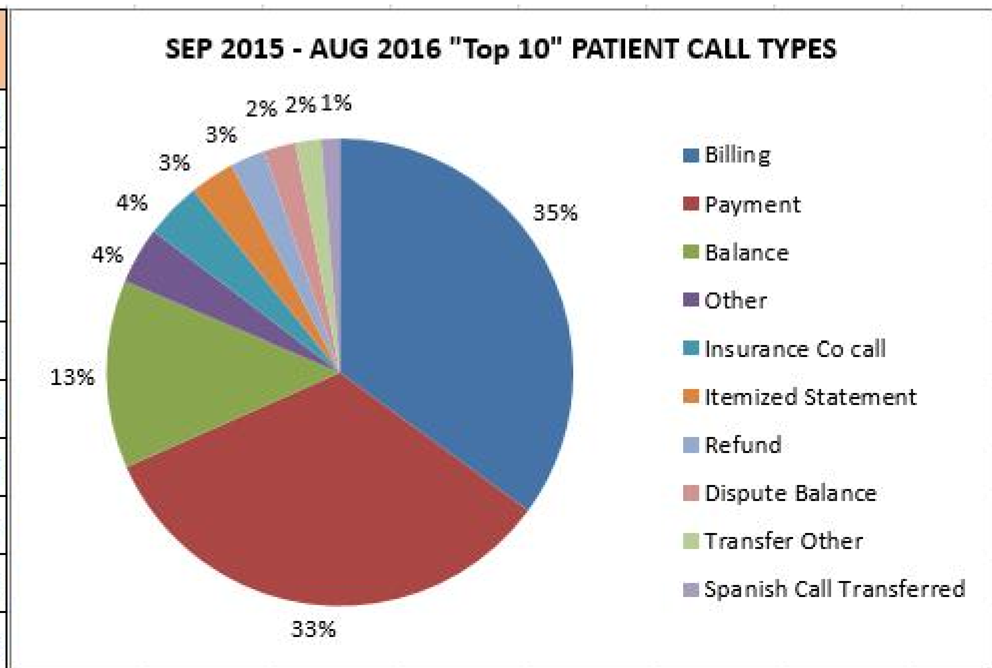

Appendix C – Call Volumes and Wait Times

The below graphs illustrate monthly call volumes, talk times and wait times for the scope period. Talk time increased 15% from an average of 10.85 minutes in October to 12.5 minutes in March (15%). Patient call wait time duration increased 166% from an average of 1.26 minutes in October to 3.36 minutes in March.