Office of Internal Audit

UT Southwestern Medical Center

The University of Texas Southwestern Medical Center
Denials Management Audit – University Hospitals

Internal Audit Report 14:10B

November 19, 2014

Table of Contents

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 which may exist through improvements in key revenue cycle processes. For some organizations, as much as 25% of all claims are "unclean", rejected or denied at some point in the collection process, with at least five 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 (HFMA) establishes the overall bad-debt target to be < 2-3% of revenue).

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 denials tracking and appealing procedures developed; 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

Denials are typically divided into two categories: technical and clinical. Technical denials result from factors such as claim submission errors, untimely filing, and lack of patient eligibility for date of service whereas clinical denials include medical necessity, patient type, length of stay, specific procedure, and diagnosis-mismatch issues.

Scope and Objectives

As part of the 2014 Internal Audit Plan, a Denials Management Review was performed for University of Texas Southwestern Medical Center (Medical Center). 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 Radiation Oncology area for further review and observed scheduling, registration and benefits verification. Additional denials feedback was obtained from Cancer Center – Chemotherapy, Zale Lipshy Nursing Floor 5, Saint Paul Nursing Floor 6, and Saint Paul Lab.

[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 (2)	Medium (4)	Low (4)	Total (10)

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

- **Denials Data Integrity** – Improvements are needed for ensuring the accuracy of denials related data for reporting and feedback purposes. Denial code mapping issues (51% exception rate) and denial errors (74% exception rate) were identified through testing. Additionally, insurance denial code information from Epic is not mapped to a general category allowing for more meaningful denials information to be captured and reported.

- **Departmental Denials Feedback and Reporting** – Dashboards and reporting to identify key denials statistics and historical trends did not exist. The current dashboards in place focus on resolving denials and not the identification of root causes. Additionally, the Technical Denials Team does not currently track and report summarized denials information for hospital departments.

- **Write-Offs and Contractual Adjustments** – Contractual adjustments made by Technical and Clinical Denials Staff are not systematically restricted or approved. System approval limits and an automated approval work queue are in place for denial write-offs; however, the clinical denial write-offs are mapped to the technical denial approval work queue which would cause clinical denials to not be worked immediately, resulting in delays.

- **Concurrent Review Authorization Denials** – The Utilization Review (UR) team does not always initiate the appeal process upon first notification of a denial during the concurrent review authorization process or communicate with the Clinical Appeals Team to do so.

- **Denial Code Work Queue Mapping** – A standard process is not in place to identify non-standard HIPAA remit codes and ensure they are mapped to the appropriate technical and clinical work queues to be properly worked.

- **Medicare Billing Overlaps** – Frequent overlaps for Medicare accounts occur with inpatient services during the date of service span of an outpatient recurring bill, resulting in a claim overlap rejection and payment delay.

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.

Executive Summary

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

UTSouthwestern Medical Center

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium-High  1. **Denials Data Integrity** Data integrity is critical to ensuring the accuracy of denials related data for reporting and feedback purposes. The following issues were identified: • Data integrity issues were found within the denials report for 26 out of 35 (74%) denials tested. Errors were identified within one or more of the following categories: admission date, discharge date, total billed charges, payor, total payment amounts, • There were mapping issues identified in 18 out of 35 (51%) accounts tested with denials evidenced on the EOB/eRA that were not included within the denials report. These results indicate all denial remittance codes are not captured within Epic denials reporting and manual remittance codes are sometimes not included within the Epic population. • Denials remittance codes did not reconcile with Epic data; A common remittance code (i.e., 31 - Patient cannot be identified as our insured) was not present within the denials report provided for testing, indicating it may not be mapped appropriately within the system. • Insurance denial code information captured from the remittance advice (RA) within Epic is not mapped to a general category, which would allow for more meaningful denials information to be captured, aggregated, and reported.	1. Perform root cause analysis to determine the common reasons for the testing exceptions noted and establish appropriate remediation action plans. 2. Map all insurance denial codes to summary categories to ensure meaningful data is captured. Sample denial categories include service not covered; maximum benefits exhausted; service date not covered; filing date exceeded; not medically necessary; diagnosis/coding issues; no pre-cert/authorization; not medically necessary; documentation does not justify care; information requested/additional documentation required; etc.	**Action Plan Owners:** Director, Patient Access and Financial Services Associate Director for Hospital Business Systems Assistant Director, Patient Financial Services Assistant Director, Patient Financial Services Revenue Integrity **Target Completion Dates:** December 31, 2014 **Management Action Plans:** 1. 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. 2. We will review current remittance code to summary denials code category mapping to verify accuracy and make updates as necessary.

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium-High 2. **Departmental Denials Feedback and Reporting** Opportunities exist for providing denials feedback to respective departments to focus on denial resolution, root cause identification, and process improvements to prevent reoccurrence of denials. Specifically, the Technical Denials Team does not currently track and report summarized denials information for hospital departments. The Clinical Denials Team has recently implemented monthly clinical denials write-off reviews with key outpatient departments (e.g., Cancer Center, Imaging, Radiation Oncology, and Infusion Center) where they provide customized reports with clinical write-off information. However, without consistent feedback highlighting all denial opportunities, departments who may have opportunity to reduce denials are not identified and are not receiving communication about both technical and clinical denials. For example, the audit identified denials for untimely billing (i.e., claims not submitted within 7 days post discharge) for 8 out of 35 (23%) denials tested. Reporting of the denials back to the department could result in decrease in denials of this type. In addition, while denials dashboards and reporting exist, current dashboards and reporting are focused on resolving denials and not identifying key denials statistics and historical trends. The denials rate calculated and communicated to financial and clinical leadership is a denials write-off rate and only includes clinical denials. This is a valuable metric to track and report; however, additional denials statistics should also be tracked such as below; Management dashboards do not include key denials	1. Perform root cause analysis to determine the common reasons for billing delays and work with the applicable stakeholders to decrease the bill hold time. 2. Utilize available denials information to track, trend, and report on all rejected and/or denied claims, including technical and clinical denials as well as denials that were overturned, and provide reporting to responsible departments/areas to identify and remediate root cause issues. This will help the Medical Center to ensure responsible parties are aware of issues that result in denied or rejected claims in order to prevent future occurrences of the same issue. 3. Establish accountability feedback loops that require departments to report back on actions taken to address root cause issues. Expand upon the current process that the clinical denials team has implemented around reviewing clinical denial write-offs with certain departments to include a focus on trends around all initial technical and clinical denials experienced. 4. Begin tracking best practice denials and appeal metrics similar to the ones listed in the observation and trend them from month to month. Label existing management dashboards in a way to clearly reflect the statistic being calculated. In addition, utilize these metrics to benchmark the clinical and technical denials processes against others in the industry to compare UTSW's denials management program and historical performance to similar hospitals throughout	**Action Plan Owners:** Director, Patient Access and Financial Services Assistant Director, Patient Financial Services Assistant Director, Patient Financial Services Revenue Integrity **Target Completion Dates:** 1-5a. December 31, 2014 5b. March 15, 2015 **Management Action Plans:** 1. Technical and Clinical Denials Leadership will review the information provided related to billing delays and will follow-up with the appropriate stakeholders as needed. This review and follow-up will be completed by December 31, 2014. 2. The Technical Denials Team will utilize the key metrics and reports identified in observation #1 to begin reporting meaningful technical denials feedback to the hospital clinical departments/ Patient Access Services. This will be completed by December 31, 2014. 3. The Clinical Denials Team will continue to work with the hospital clinical departments and will implement feedback avenues with other applicable departments, including Patient Access Services, UR Committee, and Decision Support (Charge Description Master) to provide meaningful feedback related to metrics as well as specific opportunities to identify root cause issues that can assist in preventing future denials. Additional departments will continue to be added to existing departmental meetings. A strategic approach will be utilized to accomplish

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
statistics such as: • Overall initial denials rate • Clinical initial denials rate • Technical initial denials rate • Denials overturned by appeal • Denials write-off rate	the region and country. HFMA defines the clinical initial denials rate to be less than 5% and the technical initial denials rate to be less than 3% with a combined overall initial denials rate not to exceed 4%. HFMA also establishes the denials overturned by appeal rate as 40% - 60%. Best practice organizations have been able to achieve an overall denials write-off rate less than 0.5% on a consistent basis. 5. Perform a cost-benefit analysis to determine whether the implementation of a denials management system would be beneficial to the organization or whether current denials information captured from RA posting is sufficient for the organization's needs.	this and ensure meaningful data is captured for the departments. This will be completed by December 31, 2014. 4. We will identify the key denials metrics to track, trend, and report. Ensure these definitions are incorporated into future reporting developed. 5a. We will work with MedeAnalytics (denials management system vendor) to assist in reporting denials metrics based on electronic remittance advice (eRA) information received. This will be an incomplete population, as paper remit codes will be incorporated in a later phase; however, this will provide data for a majority of denials in a more timely manner. NOTE: If the desired reports and metrics are not achievable with data available through MedeAnalytics, the team will work to accomplish this through the Epic 2014 upgrade. In this scenario, the target completion date will be modified. 5b. We will continue to work with MedeAnalytics to assist with solutions to incorporate the manual (non-electronic) remittance information into denials reporting and calculate key metrics identified during Phase One.
Risk Rating: Medium 3. **Write-Offs and Contractual Adjustments** • Contractual adjustments made by Technical and Clinical Denials Staff are not systematically restricted or approved. System approval limits and an automated approval work queue are in place for denial write-offs; however, the clinical denial write-offs are mapped to the technical	1. Provide training to clinical appeals staff to ensure they understand the scenarios when an appeal less than $250 should or should not be made. 2. Update work queue logic to appropriately route clinical denial approvals to clinical denial management. 3. Implement a standard review of contractual adjustments to occur for a specific number of	**Action Plan Owners:** Director, Patient Access and Financial Services Assistant Director, Patient Financial Services Assistant Director, Patient Financial Services Revenue Integrity **Target Completion Dates:** 1-2. Complete

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
denial approval work queue. Clinical Denials Leadership spot checks contractual adjustments greater than $1,000 but this review is not formalized in regards to how many and how often adjustments are reviewed. • Through observation, Audit noted clinical denials less than $250 were not being reviewed and appealed. Instead, the staff observed was focusing on all denials greater than $250 and manually writing-off the denial amounts less than $250. Audit noted at least 1,186 clinical related transactions under $250, totaling $83,936 in write-offs during 7/1/2013 – 6/30/2014. Per Clinical Denials Leadership, the expected process is to review the clinical denial less than $250 and appeal it if the level of effort associated with the appeal is minimal (e.g., add an authorization number, provide additional piece of documentation, etc.).	adjustments each week to ensure the account was 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 being applied appropriately as well. System approval limits should also continue to be explored as the best practice approval control for all adjustments. 4. Implement a standard review/audit of write-offs to occur for a specific number of write-offs each month to ensure the account was adjudicated appropriately and the write-offs applied by the staff are appropriate. This could include a write-off adjustment review by account to identify any users bypassing system controls and making multiple adjustments less than their designated threshold.	2-3. January 1, 2015 **Management Action Plans:** 1. Clinical Denials Leadership has addressed the write-off issue for denials less than $250 with Clinical Denials Staff to ensure denials less than $250 are considered for resolution prior to write-off occurring. 2. IR has completed the build to route clinical denial write-offs to the Clinical Denials Assistant Director; this is pending a move into the production environment. In the interim, it is important to note that write-offs are still following the established approval protocol based on dollar amount and title. The Clinical Denials Assistant Director is also performing a spot check of clinical denial write-offs. 3. A new departmental trainer was recently hired and will be developing formalized training related to write-offs and contractual adjustments. This training will be presented to all Technical and Clinical Denials Staff. A formalized process for contractual adjustments will be implemented; this will include a review of an adjustment report and will be aligned with action plans from Credit Balance Audit findings. 4. In addition, we will establish a process to regularly review a write-off report to ensure write-offs are being applied appropriately and system controls are not being circumvented.
Risk Rating: Medium 4. **Concurrent Review Authorization Denials** The Utilization Review (UR) team does not always initiate the appeal process upon first notification of a	1. Ensure the concurrent review and authorization responsibilities of UR Nurses and Care Coordinators are well defined and training is provided. This should include the expectations that denied days are appealed	**Action Plan Owners:** Director of Clinical Documentation Improvement, Utilization Review, and Social Work Assistant Director, Patient Financial Services

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
denial during the concurrent review authorization process or communicate with the Clinical Appeals Team to do so. In addition, there is no formal process in which concurrent authorization documentation (e.g., clinical information faxed to the payor, letters sent from the payor authorizing or denying days, appeals submitted, etc.) is maintained and available for later use by the Clinical Appeals Team to be used for training and feedback to reduce the number of future denials.	to the full extent possible at the time the denial occurs (i.e., while the patient is in-house or shortly after discharge) and that all information related to concurrent authorization approval/denials is maintained in the Allscripts Care Management system. 2. Determine whether the UR Nurse or Clinical Appeals Team is responsible for appealing concurrent review authorization denials. If it is determined the Clinical Denials Team is responsible, a system should be created to provide information to the Clinical Denials Team at the point of denial. If the UR Nurses are responsible, appeal letter templates and training should be provided to the UR Nurses. 3. Utilize information available in the Allscripts Care Management system to assist in unresolved denied days and/or erroneous authorization denials on the back end.	Revenue Integrity **Target Completion Dates:** Complete **Management Action Plans:** 1. The Director of Clinical Documentation Improvement, Utilization Review, and Social Work will determine next steps towards clearly defining the role of the UR Nurses and Care Coordinators in the authorization and concurrent review appeals process, including proactively addressing concurrent denials and documenting the utilization review/appeals actions taken in the Allscripts Care Management system. 2. The Director of Clinical Documentation Improvement, Utilization Review, and Social Work will work with Clinical Denials Leadership to determine whether the UR Nurse or Clinical Appeals Team is responsible for appealing concurrent review authorization denials and establishing a system for communication. A process will be documented and training will be provided by November 1, 2014. 3. The Clinical Appeals Team will utilize information available in Allscripts to assist in unresolved denied days and/or erroneous authorization denials on the back end. This will be effective on November 1, 2014.
Risk Rating: Medium 5. **Denial Code Work Queue Mapping** A standard process is not in place to identify non-standard HIPAA remit codes and ensure they are	1. Implement a process where cash posting staff track non-standard remit codes not available in Epic as a selection. Any codes identified should be sent to the Supervisor weekly.	**Action Plan Owners:** Director, Patient Access and Financial Services Associate Director for Hospital Business Systems Assistant Director, Patient Financial Services

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
mapped to the appropriate technical and clinical work queues. During on-site observation, Audit noted one example where non-electronic remit information was erroneously routed to a technical denial work queue rather than a clinical work queue. Specifically, a paper Superior Medicaid Explanation of Benefits (EOB) with multiple accounts was manually scanned, and remit codes were manually keyed into each Epic account. Superior Medicaid does not use the standard HIPAA remit codes, but they provided a remit code description key on the last page of the EOB packet. For one account ($11,714.05 charges denied), the remit code on the EOB was "EB" (Denied by medical services), but "A1" (Authorization not on file) was keyed into Epic. Not only was this a manual key error, but both of these remit codes are considered clinical and should be mapped to a clinical work queue rather than a technical work queue.	2. Perform a quarterly review of the complete list of remittance codes to determine if additional codes should be mapped across all reportable attributes (i.e., standard HIPAA denial code, HB action, corresponding clinical or technical work queue, and summary categories) within Epic. In addition, this review should focus on whether each code is routing to the appropriate denial work queue; the definition (clinical versus technical); and action assigned. Any new codes should be mapped at this time (i.e., prior to payors utilizing the new codes).	Assistant Director, Patient Financial Services Revenue Integrity **Target Completion Dates:** 1. Complete 2a-2c. December 31, 2014 **Management Action Plans:** 1. Cash Posting Staff will manually track non-standard denial codes by payor identified through their daily processes. Weekly, Clinical and Technical Denials Leadership will review any non-standard denial codes identified through the cash posting process and use a standard form created by the Technical Denials Team to complete all information needed to map the information appropriately within Epic. This information will be added to an Information Resources (IR) ticket for addition to the Epic system. This process has been implemented. 2a. A written process related to denial remittance code mapping maintenance will be developed. This process will be formally documented as of December 31, 2014. 2b. See observation #1, action plan #2 for action plan related to mapping remit codes to key denials categories. This will be completed by December 31, 2014. 2c. Ensure remittance codes are mapped to the correct denials classification (clinical vs. technical) and the correct work queue. This will be completed by December 31, 2014.
Risk Rating: Medium	Research the root causes for the Medicare billing overlaps and determine if an edit can be	**Action Plan Owners:** Director, Patient Access and Financial Services

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
6. **Medicare Billing Overlaps** Through observation, Audit noted frequent overlaps for Medicare accounts with inpatient services during the date of service span of an outpatient recurring bill. For example, a patient receiving outpatient services during the month of March also had an inpatient stay during this same month, resulting in a claim overlap rejection. Once the billing error (Medicare rejection of CO60 "Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services") is received on the back end, the billing staff uses the 'combine account' function to move charges to one account and manually reverses out the adjustments to combine all information to one of the accounts for that date of service before resubmitting the claim. The process for manually adjusting and combining the separate accounts further exposes the new claim to manual entry errors that could result in an additional denial. Audit identified untimely identification of Medicare Overlap issues for 5 out of 35 (14%) denials tested.	implemented to identify these recurring accounts with an inpatient overlap prior to billing. If an edit can be implemented, these recurring accounts should be billed with occurrence span code 74 to identify the inpatient stay, day of outpatient surgery, or outpatient hospital service subject to the Outpatient Prospective Payment System on the recurring account claim. Another alternative discussed is moving Cancer Center encounters to single visit billing, which would also reduce these errors	Associate Director for Hospital Business Systems Assistant Director, Patient Financial Services Assistant Director, Patient Financial Services Revenue Integrity **Target Completion Date:** December 31, 2014 **Management Action Plan:** Clinical and Financial Denials Leadership will determine Medicare overlap causes and will work with IR to determine what can be done systematically to prevent these claims from being submitted. Research will be completed by December 31, 2014 and further action will be determined based on the research performed.
Risk Rating: Low 7. **Productivity and Quality Assurance for Technical and Clinical Denials Staff** Although some productivity reporting exists in Epic, a "best practice" does not exist and is not documented to utilize productivity metrics to measure Technical and Clinical Denials Staff productivity. In addition, the quality assurance process is not formalized to specify how many accounts are reviewed each month and which specific attributes are reviewed. As a result, consistent feedback is not provided to Technical	Establish a Technical and Clinical Denials Staff monitoring and training program to improve the overall productivity and quality of staff activities as follows: - Establish standard technical and clinical denials productivity metrics so management is able to monitor and address issues as they arise. Productivity metrics can help identify training opportunities for Technical and Clinical Denials Staff. The productivity method currently being implemented around "activity codes" and providing each code	**Action Plan Owners:** Director, Patient Access and Financial Services Associate Director for Hospital Business Systems Assistant Director, Patient Financial Services Assistant Director, Patient Financial Services Revenue Integrity **Target Completion Date:** December 31, 2014 **Management Action Plan:** Productivity/performance measures and quality

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
and Clinical Denials Staff on a defined periodic basis. There is a project currently underway to improve system "activity codes" that will improve the monitoring capability for Technical and Clinical Denials Staff. However, this will only provide insight into how many accounts are touched by a staff person each day. A quality assurance program will still need to be implemented to ensure staff is working accounts appropriately. Though onboarding processes do exist at the UTSW organizational level, they are not formalized within the Technical and Clinical Denials departments. In addition, there is no formalized training plan or on-going education/training for appeal staff. As a result, most personnel only receive on-the-job training. Audit identified QA opportunities for 8 out of 35 (23%) denials tested, including the potential for more detailed appeal notes and/or explanations of tickler timeframes or accurate contractual adjustments.	with a relative weight will be one touch point to determine how many accounts staff works each day. Productivity analysis should be performed in conjunction with a quality assurance process to ensure Technical and Clinical Denials Staff are adequately resolving the accounts they work. - Develop key performance quality measures in order to monitor and measure personnel performance against established metrics by role to ensure denied claims are worked appropriately and completely for proper resolution. Personnel performance that falls below the established metric(s) should be addressed with the individual for training purposes and to identify improvement opportunities. - Implement a formal training program for all Technical and Clinical Denials Staff, as well as continuing education, as processes and Management's expectations change. The training program should outline the minimum expected amount of time that new staff will train through shadowing, as well as the quality assurance process that is in place to ensure new and existing staff are performing at an acceptable level. Continuing education should be provided as programs or processes change, or when performance trends are noted that need to be addressed. This type of training could be accomplished in existing formal office meetings or through an outside service.	assurance metrics will be implemented in a phased approach. A formalized plan will be developed regarding the implementation of these processes and additional action steps will be determined based on this plan. The plan will be developed by December 31, 2014.

UTSouthwestern Medical Center

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Low 8. **Guidelines and Reference Materials** Timeliness and prioritization guidelines for core work queues and clinical/technical denials work queues are not defined. Through observation, Audit noted two clinical appeal specialists who worked their queue from top to bottom with no consideration for age of the account or dollar amount. (Note: These queues were current at the time of the observation, which makes this a lower risk; however, this could be a more significant risk at points throughout the year when the work queue volume increases). In addition, there is not currently a technical denials work queue aging report available that allows Technical Denials Management to monitor the overall aging of accounts within the work queues. Instead, Technical Denials Management has to investigate the details of each individual work queue and export custom reports for each work queue in order to ensure accounts are being worked timely. This is a time intensive process as there are 49 technical denials work queues. In addition, the work queue aging is not present in all technical denial work queues. The Clinical Denials Team has been utilizing the custom Clinical Denials Work Queue Activity Report for clinical work queue monitoring.	1. Adapt the custom Clinical Denials Work Queue Activity Report for all denial work queues and make the report available to Technical and Clinical Denials Leadership. If possible, this report should be adapted to where work queue detail can be 'drilled into' from the dashboard report. 2. Add work queue aging to all denials work queues as a monitoring tool. 3. Monitor timely filing deadlines for each payor and prioritize denied claims based on the claim dollar amounts, age from discharge date, and timely filing deadlines. Establish timeliness and prioritization guidelines for core work queues and clinical/technical denials work queues to define the expected process for resolving accounts within each queue. These guidelines should identify teams responsible for each denial type, the expectation regarding timeliness for responding to payor requests, the appropriate actions to take within each step of the process, documentation required within Epic, and the timeliness standard for appealing a denied claim. 4. Provide appropriate communication to all appropriate staff regarding the expected process for working various queues. Once guidelines are established, provide appropriate communication and training regarding the specific guidelines to ensure all staff is aware of the guidelines and knows where they are located.	**Action Plan Owners:** Director, Patient Access and Financial Services Associate Director for Hospital Business Systems Assistant Director, Patient Financial Services Assistant Director, Patient Financial Services Revenue Integrity **Target Completion Dates:** 1-2. Complete 3. December 31, 2014 **Management Action Plans:** 1. IR has adapted the custom Clinical Denials Work Queue Activity Report for all denial work queues and has made this report available to Technical and Clinical Denials Leadership. 2. Technical Denials Leadership submitted an IR ticket requesting work queue aging be added to all technical denial work queues. 3. Timeliness and prioritization guidelines will be implemented in a phased approach. A formalized plan will be developed regarding the implementation of these processes and additional action steps will be determined based on this plan. The plan will be developed by December 31, 2014.

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Low 9. **Clinical Appeals** General appeal letter templates exist for clinical denial appeals (Authorization and Medical Necessity); however, the templates should be more robust and better defined for ease of staff use and accuracy. Additionally, the clinical appeals team currently requests copies of patient medical records through Health Information Management (HIM), which delays the appeals process by 3 to 10 days. Appeal letters are not scanned into the scanning database associated with the patient account which is the expected process. Instead, each appeals representative has his/her own methodology for saving these, which is inefficient if others need to review or work the account. Audit also observed instances where coding follow-up was done through email rather than through the work queue itself.	Communicate and formalize expectations for Clinical Appeals staff related to the following: - Develop standard appeal templates that include standard appeal language that has been successful in the past related to the introduction, closing and denial type. The clinical case made for each appeal will be unique to the specific patient situation and should continue to be customized to the specific patient and reason for denial. This should be considered as a free text area within the appeal template. - Print the medical record from Epic rather than requesting this from HIM to decrease turnaround time in instances where a complete medical record is not needed or the medical record documentation is succinct. - Scan appeal letters into the database associated with the patient account. In addition, one component of the Quality Assurance process going forward should be to ensure appeal letters are scanned into the database appropriately. - Follow-up through the work queue itself rather than through email outside of the work queue.	**Action Plan Owner:** Assistant Director, Patient Financial Services Revenue Integrity **Target Completion Date:** Complete **Management Action Plan:** Management has started addressing each item identified related to Clinical Appeals with staff. Formal appeal templates and medical record request and scanning procedures will be formalized by November 1, 2014.
Risk Rating: Low 10. **Denial Correspondence** Denial correspondence is received through a variety of sources (e.g., through a lockbox, through interdepartmental mail after being sent to a department specific address, through the CFO's	1. Consider routing all denial and payment correspondence through a centralized PO Box to minimize the risk of correspondence not being received by the appropriate party and/or not being received timely. 2. A process to communicate the mail code change should be taken into consideration	**Action Plan Owners:** Chief Financial Officer Director, Patient Access and Financial Services Assistant Director, Patient Financial Services Assistant Director, Patient Financial Services Revenue Integrity

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
mail code, etc.). In addition, mail codes may be changing when St. Paul University Hospital closes and the new William P. Clements Jr. University Hospital opens in November 2014.	and addressed as soon as possible as it relates to the receipt and processing of payor correspondence. 3. Develop a process to notify the CFO's office when payors do not utilize the established centralized address for correspondence. The CFO's office should continue the current process to reach out to payors when correspondence is continually received at the wrong address.	**Target Completion Dates:** 1-3. Complete **Management Action Plans:** 1. We will continue the current process of routing payor correspondence through a centralized address. 2. A process will be developed to update the W-9 information with payors as soon as new mail codes are established. 3. A process will be developed to communicate correspondence being received through inappropriate channels to the CFO's office.

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:

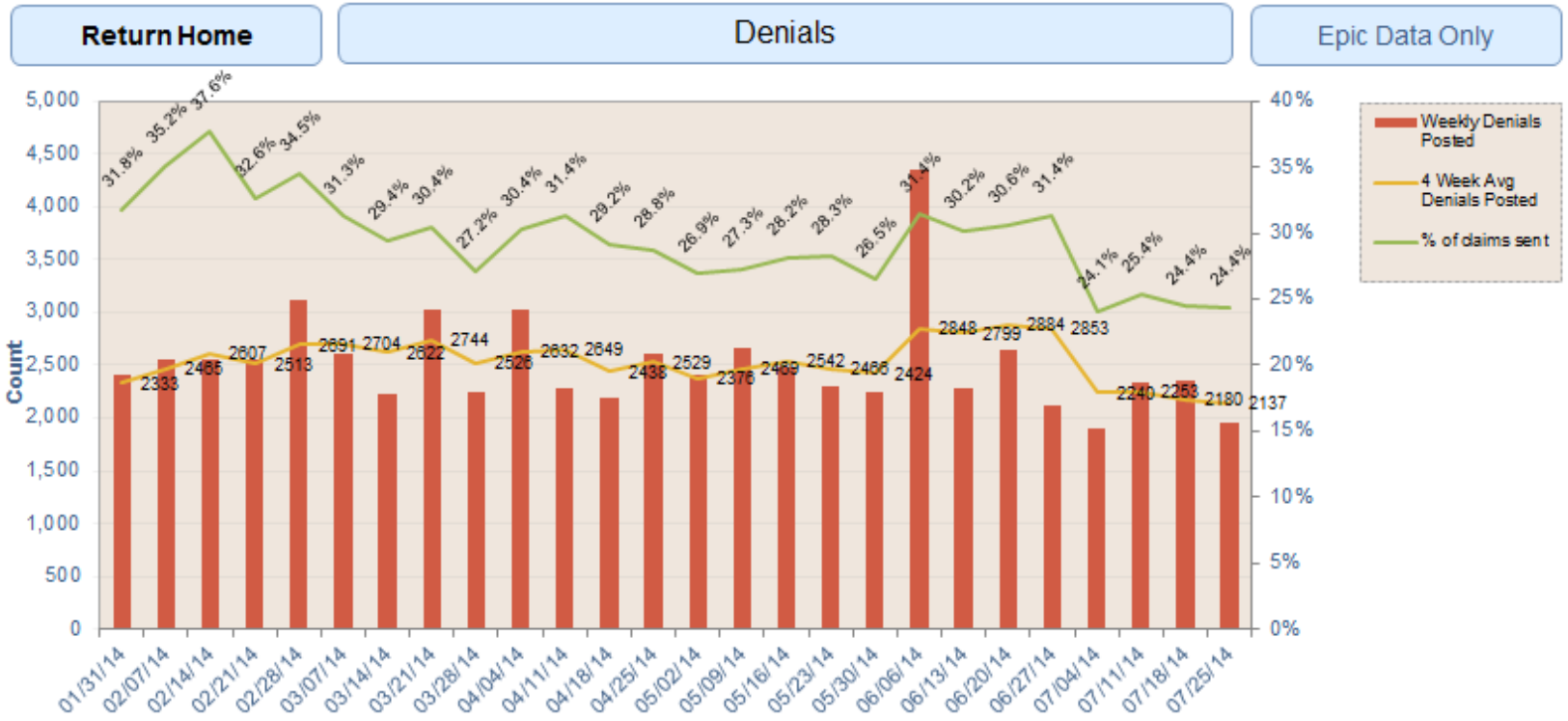
	Degree of Risk and Priority of Action	
Risk Definition - The degree of risk that exists based upon the identified deficiency combined with the subsequent priority of action to be undertaken by management.	**High**	The degree of risk is unacceptable and either does or could pose a significant level of exposure to the organization. As such, immediate action is required by management in order to address the noted concern and reduce risks to the organization.
	Medium/High	The degree of risk is substantially undesirable and either does or could pose a moderate to significant level of exposure to the organization. As such, prompt action by management is essential in order to address the noted concern and reduce risks to the organization.
	Medium	The degree of risk is undesirable and either does or could pose a moderate level of exposure to the organization. As such, action is needed by management in order to address the noted concern and reduce risks to a more desirable level.
	Low	The degree of risk appears reasonable; however, opportunities exist to further reduce risks through improvement of existing policies, procedures, and/or operations. As such, action should be taken by management to address the noted concern and reduce risks to the organization.

It is important to note that considerable professional judgment is required in determining the overall ratings presented on the subsequent pages of this report. Accordingly, others could evaluate the results differently and draw different conclusions.

It is also important to note that this report provides management with information about the condition of risks and internal controls at one point in time. Future changes in environmental factors and actions by personnel may significantly and adversely impact these risks and controls in ways that this report did not and cannot anticipate.

Appendix B – Denials Data

The graph below represents weekly denials trending for the period January 31, 2014 through July 25, 2014.



Denials Count: Transaction counts of denials posted in Epic.
Denials as % of Claims Sent is calculated using the 4 week average denials posted, divided by the 4 week average claims sent assuming a 4 week delay from claim to denial.

Appendix B – Denials Data

The tables below represent the top denials (month to date and year to date) as of July 28, 2014.

Top Twenty Denials Posted (Month to Date)

	Denial Reason	Posted Amount	Count
1	18-DUPLICATE CLAIM/SVC.	$8,087,415	408
2	B13-CO - PREVIOUSLY PAID.	$4,002,426	289
3	119-PR - PAYER REFUND AMOUNT -	$1,400,925	84
4	197-CO - PMT ADJ NON COVERED P	$947,740	148
5	16-45CKS INFO NEEDED FOR ADJUD	$857,052	365
6	29-TIME LIMIT FOR FILING HAS E	$802,530	142
7	XFR50-XFR - CLIN DEN, MEDICAL	$631,675	95
8	A1-CO - CLAIM DENIED CHARGES.	$620,397	54
9	XFR15-XFR - CLIN DEN, AUTH NUM	$616,009	64
10	96-NON-COVERED CHARGES.	$560,322	734
11	252-AN ATTACHMENT/OTHER DOCUME	$532,832	52
12	23-9/REDUCED, CHARGES PAID, CO	$524,014	170
13	15-9, AUTH NUM MISSING OR INVA	$469,253	18
14	22-OA - CLAIM DENIED/REDUCED,	$362,743	208
15	148-CO - PAYMENT ADJUSTED, PAY	$351,114	8
16	B5-PR - PAYMENT ADJUSTED BECAU	$256,648	141
17	50-CO - NON-CVD, NOT DEEMED A	$245,560	294
18	27-PR - EXPENSES INCURRED AFTE	$236,903	96
19	151-CO - FLEXIBLE SPENDING ACC	$192,954	239
20	204-CO - PER REG/AGREE CAN'T B	$135,964	11

Top Twenty Denials Outstanding (Last 12 Months)

	Denial Reason	Outstanding Amount	Count
1	18-DUPLICATE CLAIM/SVC.	$18,453,524	1704
2	B13-CO - PREVIOUSLY PAID.	$3,645,325	393
3	50-CO - NON-CVD, NOT DEEMED A	$3,049,923	844
4	16-45CKS INFO NEEDED FOR ADJUD	$2,128,513	592
5	197-CO - PMT ADJ NON COVERED P	$2,077,572	189
6	XFR50-XFR - CLIN DEN, MEDICAL	$2,042,717	292
7	96-NON-COVERED CHARGES.	$1,852,944	1413
8	A1-CO - CLAIM DENIED CHARGES.	$1,271,300	158
9	29-TIME LIMIT FOR FILING HAS E	$1,150,799	432
10	XFR15-XFR - CLIN DEN, AUTH NUM	$1,021,049	124
11	22-OA - CLAIM DENIED/REDUCED,	$931,615	456
12	119-PR - PAYER REFUND AMOUNT -	$670,698	111
13	151-CO - FLEXIBLE SPENDING ACC	$641,360	132
14	27-PR - EXPENSES INCURRED AFTE	$535,260	257
15	55-PR - DENIED, PXDEEMED EXPE	$485,056	51
16	23-9/REDUCED, CHARGES PAID, CO	$484,355	93
17	15-9, AUTH NUM MISSING OR INVA	$450,141	19
18	150-CO - THIS CLAIM DENIED, PA	$439,064	26
19	252-AN ATTACHMENT/OTHER DOCUME	$424,836	17
20	B5-PR - PAYMENT ADJUSTED BECAU	$297,270	73

Appendix B – Denials Data

The table below represents claims, edits, and denials trending as of July 28, 2014.

Claims and Edits

Compare To: 4 Week Ave

	Unit	This Week	Last Week	% Change	4 Week Ave	% Variance
Coding	Days	3.4	3.4	1.4%	4.2	-18.6%
	Dollars (M)	$22.2	$21.8	1.8%	$27.1	-18.1%
Edits	Inpatient (M)	$17.6	$12.3	42.6%	$16.9	4.2%
	Outpatient (M)	$24.8	$25.4	-2.6%	$33.0	-24.9%
Claims Sent	Volume	8,963	10,265	-12.7%	8,745	
	Dollars (M)	$44.4	$53.2	-16.6%	$52.0	
Denials	Count	1,948	2,355	-17.3%	2136.5	
	% claims sent*	24.4%	24.4%	-0.3%	25%	

**% Claims Sent is calculated by dividing the Count of Denials by the 4 week average claims sent with a 4 week lag.*