Office of Internal Audit

UT Southwestern Medical Center

Revenue Cycle – Denials Management Audit

Internal Audit Report 18:04

February 23, 2018

Table of Contents

Executive Summary

Background

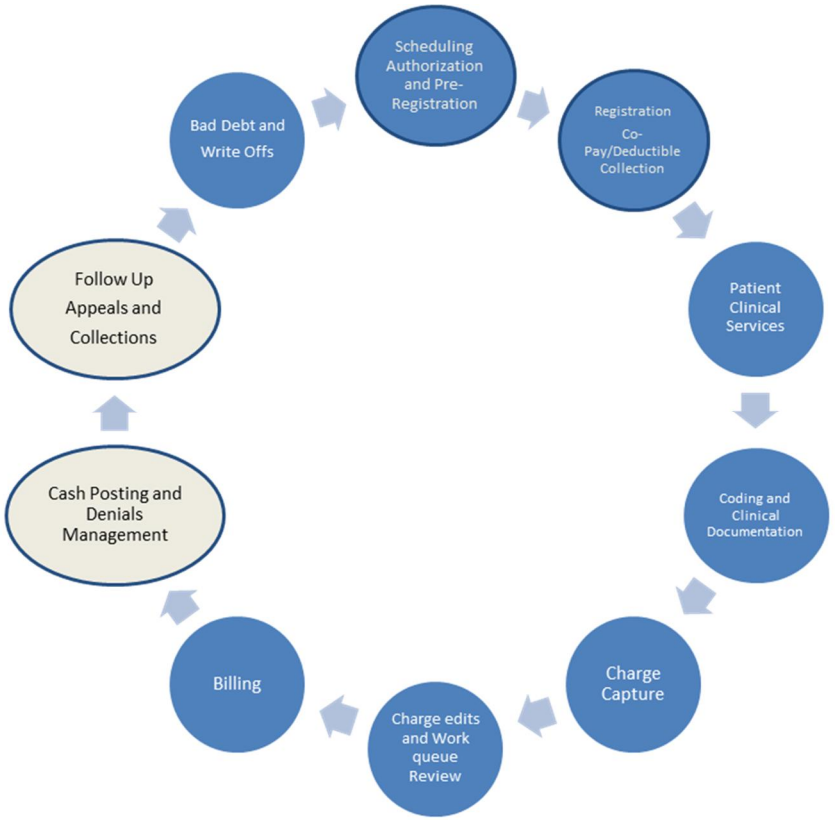
Denials management is the process of collecting, tracking, reporting, trending, forecasting, measuring, and managing claims denied for payment by insurance payers. An effective denials management program enables healthcare providers to better manage revenue loss; one of their most expensive business risks. Key benefits of an effective program include: identification of principle reasons for revenue loss; efficient processes for denials tracking and appeal; reduced denial volumes; improved cash collections; improved patient satisfaction; and increased communication and collaboration among internal departments.

Denials are typically divided into two categories, technical and clinical, as follows:

- *Technical denials* may result from factors such as claim submission errors, untimely claim filing, lack of patient eligibility for insurance coverage as of the date of service, and unilateral decisions by the payor.
- *Clinical denials* result from payer plan coverage factor including medical necessity, patient type, length of stay, specific procedure, and diagnosis-procedure mismatch issues.

The Revenue Cycle Operations team, hospital leadership and clinical department leadership all have responsibilities for the denials management program at UT Southwestern Medical Center (Medical Center). The denials management activities are divided into two groups – hospital and professional.

Revenue Cycle Operations Process Map



The Revenue Cycle Operations chart above includes, as highlighted, the steps reviewed during this audit.

Executive Summary

Professional Denials Management

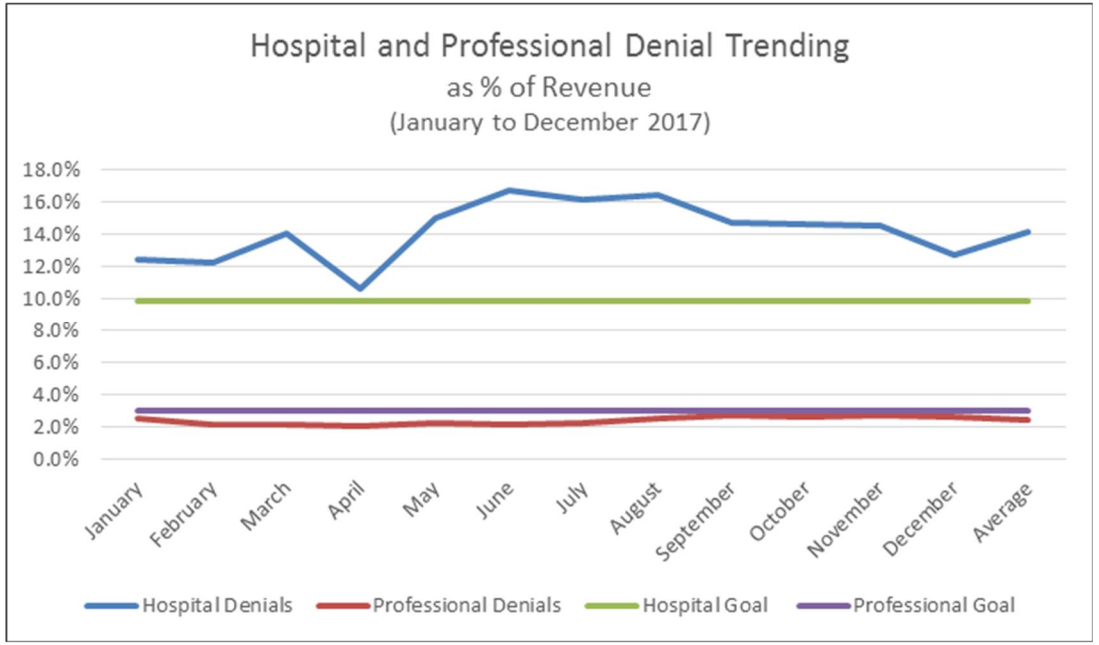
For departments whose revenue cycle functions are within the centralized Revenue Cycle Operations, clinical denials are managed centrally by the Revenue Cycle Operations team reporting to the Associate Vice President of Revenue Cycle Operations. Eight clinical departments, are responsible for performing revenue cycle functions within their departments and report to their respective department chairs. During calendar year 2017, professional denials numbered approximately 454,000 (1% of total claims) totaling $80M, which were analyzed and remediated by 115 employees (centralized resources only and does not include decentralized department resources with responsibilities for managing denials). All professional technical denials are centralized and managed by Revenue Cycle Operations.

Hospital Denials Management

Hospital technical denials are managed by the Revenue Cycle Operations team and hospital clinical denials are managed by the Decision Support team, which is a hospital department. During calendar year 2017, the hospital denials management teams received approximately 94,000 denials (17% of total claims) totaling $900M, which were analyzed and remediated by 50 employees.

This graph provides trending information as percentage of revenue for both hospital and professional denial rates during the audit period.

Appendix B provides additional information on denial trending.



Executive Summary

Scope and Objectives

The Office of Internal Audit has completed its Revenue Cycle – Denials Management audit. This is a risk based audit and part of the fiscal year 2018 Audit Plan.

The audit scope period included claim denial activities from January 2017 to December 2017. The review included determining the adequacy and effectiveness of process, oversight, and monitoring controls in place to ensure:

- Communication of performance metrics and dashboard reports to responsible process owners,
- Denied claims routed to work queues are resolved and resubmitted in a timely manner,
- Established denial management strategies and process to identify root causes for improvement,
- Follow up with clinical and hospital providers to educate and minimize recurrence; and
- Role-based system access and segregation of duties in processing approved claim adjustments, resubmission and write-off.

Audit procedures included interviews with stakeholders, review of policies and procedures and other documentation, substantive testing, and data analytics.

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, processes are in place to manage denials throughout the Medical Center, however opportunities exist to improve performance, ensuring denials are analyzed and remediated in a timely manner to reduce the risk of loss of collections. Additional escalation steps are needed to ensure decentralized departments are held accountable for timely denials management processing. Many of the action plans developed from the previous audit performed in 2014 related to data integrity and reporting were noted during this audit as being in place and functioning.

Revenue Cycle Operations leadership is developing a project plan to streamline the denials management process so the resources working denials transactions in work queues can focus their efforts on denials that can be analyzed and resubmitted to payors to improve Medical Center collections rather than efforts on denials categorized as informational only and will not result in additional collections to the Medical Center.

Executive Summary

Included in the table below is a summary of the observations noted, along with the respective disposition of these observations within the Medical Center internal audit risk definition and classification process. See Appendix A for Risk Rating Classifications and Definitions.

Priority (0)	High (1)	Medium (2)	Low (0)	Total (3)

The key improvement opportunities risk-ranked as High and Medium are summarized below.

Professional Denials Management

Opportunities exist for improved monitoring procedures to be in place to ensure timely analysis and resolution for denials transactions in active work queues. In addition, employee refresher training is needed to ensure employees understand expectations for timely analysis, documentation requirements and timely resolution of denial accounts. Additional escalation steps are needed to ensure decentralized departments are held accountable for timely denials management processing. Evaluation and updating of Epic work queue change management procedures is needed to prevent accounts from being placed into inactive work queues and thereby not being addressed, increasing the risk of loss of collections.

- **#1 Improve Timeliness of Review for Denial Work Queues -** Accounts in denial work queues are not consistently cleared in a timely manner, resulting in delays in resubmitting claims to payers which increased the risk of loss of revenue.
- **#2 Improve Work Queue Change Management Procedures -** Incomplete Epic change management procedures resulted in the erroneous reactivation of four work queues that had been previously deactivated and caused confusion for the Revenue Cycle Operations team and inefficiencies in routing denied charges.
- **#3 Update Security Access to the Hospital Billing System -** Revenue Cycle Operations personnel working professional denials have greater than minimum necessary access to the Epic Hospital Billing system when read only access is necessary.

Executive Summary

Priority (0)	High (1)	Medium (2)	Low (0)	Total (3)

Hospital Denials Management

Similar to professional denials, opportunities exist for monitoring procedures to be in place to ensure timely analysis and resolution of all denials in active work queues. Timeliness of review for denial accounts should be improved by updating monitoring procedures to identify accounts that remain in work queues without analysis and providing refresher training to employees to ensure they understand expectations for timely analysis. Additional escalation steps are needed to ensure hospital clinical departments are held accountable for timely denials management processing. In addition, defining responsibility for reviewing claims in the pre-billing hold category will ensure claims are resubmitted for billing in a timely manner.

- **#4 Improve Timeliness of Review for Denial Work Queues –** Accounts in denial work queues are not consistently cleared in a timely manner, resulting in delays in resubmitting claims to payers which increases the risk of loss of revenue.
- **#5 Improve Claim Processing Monitoring for the Denial Account Watch List -** Denied accounts accumulating in the Denial Account Watch List are not consistently monitored resulting in denied claims not timely addressed.
- **#6 Update Epic Security Access for Hospital Clinical Denials Team -** The Hospital clinical denials team has greater than minimum necessary access to the Epic Professional Billing system when only read access is necessary.

Management has plans to address the issues identified in the report and in some cases have already implemented corrective actions. These responses, along with additional details for the key improvement opportunities listed above are listed in the Detailed Observations and Action Plans Matrix (Matrix) section of this report.

Executive Summary

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,

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Executive Summary

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Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response

Professional Denials Management Observations

UT Southwestern Medical Center

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: High **1. Improve Timeliness of Review for Professional Billing Denial Work Queues** Accounts in denial work queues are not consistently cleared in a timely manner, resulting in delays in resubmitting claims to payers and increasing the risk of loss of revenue. As of December 31, 2017, 69% of the claims amounts in the denial follow up work queues were more than 90 days old. The following common opportunities were identified as contributing to delays in resolving denials and resubmitting claims to payors: - Monitoring tools are not consistently utilized by Supervisors to ensure work queue accounts are analyzed and appropriate follow up procedures are performed timely.	1. Define supervisor monitoring expectations for open denial accounts and work queues expectations.	**Management Action Plans:** 1. A project is being developed to streamline the denials management process to remove denials that are categorized as informational only and will not result in additional collections to the Medical Center. This will allow denial management employees to focus their efforts on denials that can be analyzed and resubmitted to payors to improve Medical Center collections. Doing this will reduce the number of items in work queues so that supervisors can monitor denials in accordance to standard operating procedures (SOPs). **Action Plan Owners:** Associate Vice President, Revenue Cycle Operations Director, Front End Medical/Surgical Billing, Medical Group Billing Operations Administration Director, Revenue Cycle and Business Systems **Target Completion Dates:** Project plan completed by April 30th to include steps for implementation.

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
- Escalation procedures are not clearly defined to hold decentralized department accountable for timely response for denials transactions routed to be addressed. When denials that are requiring additional information from departments are not addressed timely, it results in write-offs. For example, a decentralized department had six accounts totaling $82,000 in denials requiring additional information that were not submitted in a timely manner and required write off. - Denial analysis notes were not completed or did not provide details on next steps, which required additional review and development of plan to address denials.	2. Develop escalation procedures and coordinate with clinical department personnel for accountability to ensure denials related requests for information are completed in a timely manner. 3. Define additional expectations for denials teams for appropriate follow up actions including documentation requirements and provide refresher training.	2. Develop SOP to communicate to billing managers when departments are not meeting key goals (including denials), meet with Department Administrator/Chair and escalate to Medical Group and Health Affairs leadership as needed. **Action Plan Owners:** Associate Vice President, Revenue Cycle Operations Director, Front End Medical/Surgical Billing, Medical Group Billing Operations Administration **Target Completion Dates:** Completed 3. Training will be updated and all follow-up team members will be required to go through mandatory training programs. **Action Plan Owners:** Director, Front End Medical/Surgical Billing, Medical Group Billing Operations Administration **Target Completion Dates:** Initial review post training to be completed by September 30, 2018 and ongoing

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
	4. Perform periodic quality assurance reviews of open and closed denial records to ensure procedures are followed, expectations are met and identify ongoing opportunities for refresher training.	4. Centralized department QA will be shared with team members to improve analysis and documentation. **Action Plan Owners:** Director, Front End Medical/Surgical Billing, Medical Group Billing Operations Administration **Target Completion Dates:** July 31, 2018
	5. Medical Group leadership should develop a plan to ensure quality assurance functions are in place to monitor and review decentralized department work queues.	5. The Practice Plan CFO and AVP of Revenue Cycle Operations will develop a plan to allocate a QA function to monitor and review decentralized department work queues. **Action Plan Owners:** Associate Vice President of Finance, Practice Plan Associate Vice President, Revenue Cycle Operations **Target Completion Dates:** May 31, 2018

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium 2. **Improve Work Queue Routing Change Management Procedures** Incomplete Epic change management procedures (which would normally ensure changes are tested, moved into the Production environment and validated to ensure working as intended) resulted in the erroneous reactivation of four work queues that had been previously deactivated. This did not result in lost revenue, but caused confusion and inefficiencies for Revenue Cycle Operations staff, who did not realize these work queues had been reactivated and contained denied charges forwarded by a clinical department to be written off.	Evaluate the error that occurred and implement improvements to Epic change management procedures to ensure inactivated follow-up work queues are not erroneously re-activated.	**Management Action Plans:** Change management procedures will be updated such that deactivated work queue records are blocked from future Data Courier migration using the Epic Content Management tool. In addition, going forward, work queue deactivation changes will be classified as "Standard Changes," which require quality review by HSIR Technical Services team prior to migration to the production environment. **Action Plan Owners:** Director, Revenue Cycle and Business Systems Assistant Director, HSIR Technical Services **Target Completion Dates:** April 30, 2018

UT Southwestern Medical Center

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium **3. Update Security Access to the Epic Hospital Billing System** Revenue Cycle Operations personnel working professional denials have greater than minimum necessary access to the Epic Hospital Billing system when read only access is necessary. The annual Epic security review process did not identify this as a necessary adjustment. Incomplete security access review can result in greater than minimum necessary access to perform job duties.	1. Update security access permissions for Revenue Cycle Operations personnel working professional denials to allow only read access to the Epic Hospital Billing system. 2. Coordinate with the Service Now team to modify the Institutional Access Request (IAR) form if necessary to add any new roles created.	**Management Action Plans:** 1. We will review and update user templates for Revenue Cycle Operations personnel Hospital Billing users as recommended. **Action Plan Owners:** Director, Revenue Cycle and Business Systems **Target Completion Dates:** April 30, 2018 2. If a change is needed to the IAR form, the ServiceNow team will review the change within 30 days and then implement the change within 60 days. **Action Plan Owners:** Director, Revenue Cycle and Business Systems Director Information Quality, Academic and Administrative Information Resources **Target Completion Dates:** July 31, 2018

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response

Hospital Denials Management Observations

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: High **4. Improve Timeliness of Review for Hospital Denial Work Queues** Accounts in denial work queues are not consistently cleared in a timely manner, resulting in delays in resubmitting claims to payers which increases the risk of loss of revenue. As of December 31, 2017, $50M (48%) of the accounts in the work queues were aged over 90 days. The following common opportunities were identified as contributing to delays in resubmitting claims to payors: - Monitoring tools are not consistently utilized by supervisors to ensure work queue accounts are analyzed and appropriate follow up procedures are performed timely - Denial analysis notes were not completed or did not provide details on next steps, which required additional review and development of plan to address denial. Delays in analyzing denied accounts and inconsistent monitoring of work queue activities increases the risk of loss of revenue.	1. Define supervisor monitoring expectations for open denial accounts and work queue expectations. 2. Develop escalation procedures and coordinate with clinical department personnel for accountability for ensuring denials related requests for information are completed in a timely manner.	**Management Action Plans:** 1. A project is being developed to streamline the denials management process to remove denials that are categorized as informational only and will not result in additional collections to the Medical Center. This will allow denial management employees to focus their efforts on denials that can be analyzed and resubmitted to payors to improve Medical Center collections. **Action Plan Owners:** Associate Vice President, Revenue Cycle Operations Chief Financial Officer, University Hospitals Director, Revenue Cycle Operations Director, Decision Support Director, Revenue Cycle and Business Systems **Target Completion Dates:** Project plan completed by April 30th to include steps for implementation. **Management Action Plans:** 2. Develop SOPs for metrics that are not meeting goal and provide to Hospital leadership for communication to the hospital department clinical leaders.

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
		a. Metrics will be provided by the Revenue Cycle Operations team and Hospital CFO and Hospital COO will facilitate communications with hospital department clinical leaders. **Action Plan Owners:** Associate Vice President, Revenue Cycle Operations Chief Financial Officer, University Hospitals Director, Revenue Cycle Operations **Target Completion Dates:** Completed
	3. Define additional expectations for denials teams for appropriate follow up actions including documentation requirements and provide refresher training.	**Management Action Plans:** 3. Current training will be updated and additional training will be provided to staff once the project noted above is completed. **Action Plan Owners:** Associate Vice President, Revenue Cycle Operations Director, Revenue Cycle Operations Director, Decision Support **Target Completion Dates:** Completed

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
	4. Perform periodic quality assurance reviews of open and closed denial records to ensure procedures are followed, expectations are met and identify ongoing opportunities for refresher training.	**Management Action Plans:** 4. Results of quality assurance reviews will be reviewed with team members as a part of ongoing training efforts. **Action Plan Owners:** Associate Vice President, Revenue Cycle Operations Director, Revenue Cycle Operations Director, Decision Support **Target Completion Dates:** July 31, 2018 Initial review post training to be completed by September 30, 2018 and ongoing

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium **5. Improve Claim Processing Monitoring for the Denial Account Watch List** Nine hundred denial accounts that had been analyzed, corrected and submitted for rebilling to the payor did not map to a work queue and accumulated in the "Denial Account Watch List" which is not consistently monitored. As a result, these claims were not rebilled in a timely manner. Untimely monitoring of denied accounts in the Watch List increases the risk of loss of revenue.	1. Update denial routing instructions to eliminate accounts that cannot be mapped to an existing work queue. 2. Develop monitoring procedures to ensure claims placed in the Watch List are reviewed and cleared in a timely manner.	**Management Action Plans:** 1. The project noted in #1 above will update the denial routing instructions. 2. Information Resources in coordination with Revenue Cycle Supervisors will monitor the watch list daily and will work any items on this list within 24 hours. **Action Plan Owners:** Director, Revenue Cycle Operations Director, Decision Support **Target Completion Dates:** 1. Project plan completed by April 30th to include steps for implementation 2. Completed and Ongoing

Detailed Observations and Action Plans Matrix

Observation	Recommendation	Management Response
Risk Rating: Medium **6. Update Epic Security Access for Hospital Clinical Denials Team** The Hospital Clinical Denials team has greater than minimum necessary access to the Epic Professional Billing system when read only access is necessary. The annual Epic security review process did not identify this as a necessary adjustment. Incomplete security access review can result in greater than minimum necessary access to perform job duties.	1. Update security access permissions for the all Hospital Billing system users with the exception of the Specialty Billing team to allow read only access to the Professional Billing system. Specialty Billing should retain their update access to the Professional Billing system. 2. Coordinate with the Service Now team to modify the Institutional Access Request (IAR) form if necessary to add any new roles created.	**Management Action Plans:** 1. We will review and update user templates for all Hospital Billing users as recommended. **Action Plan Owners:** Director, Revenue Cycle and Business Systems **Target Completion Dates:** April 30, 2018 2. If a change is needed to the IAR form, the ServiceNow team will review the change within 30 days and then implement the change within 60 days. **Action Plan Owners:** Director, Revenue Cycle and Business Systems Director Information Quality, Academic and Administrative Information Resources **Target Completion Dates:** July 31, 2018

Appendix A – Risk Classifications and Definitions

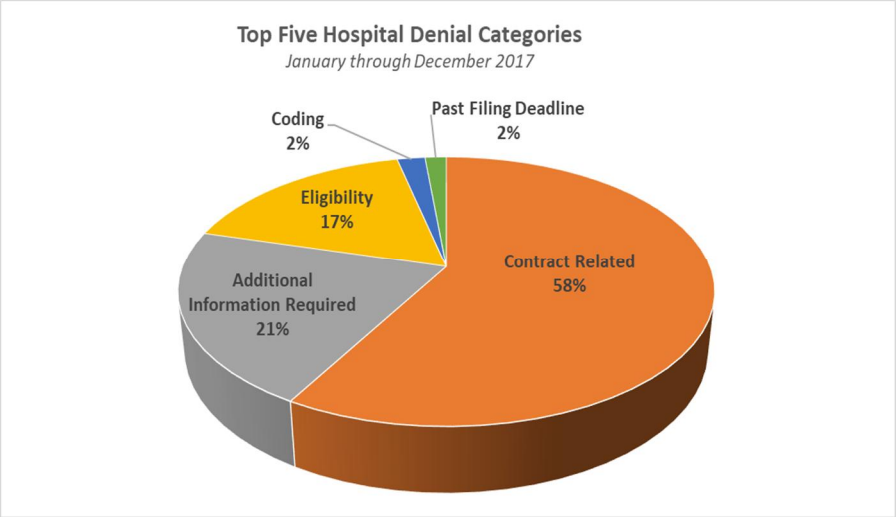
As you review each observation within the Detailed Observations and Action Plans Matrix of this report, please note that we have included a color-coded depiction as to the perceived degree of risk represented by each of the observations identified during our review. The following chart is intended to 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.	**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 the 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 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 Trending

The following graphs provide top denial categories for both Hospital and Professional accounts. The underlying root causes for these categories are reviewed and shared with department personnel to provide feedback and education and improve denial rates going forward.

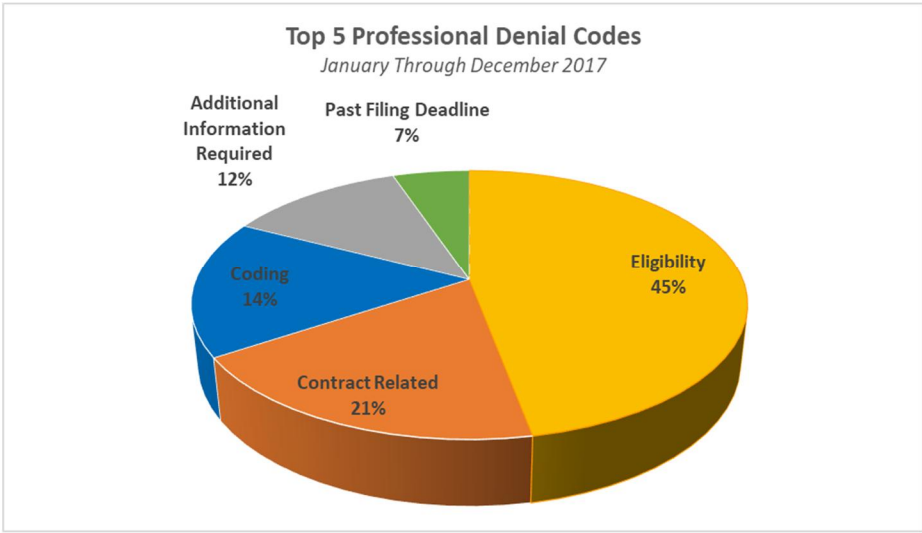


Total Hospital denials in calendar 2017 were $900M. The Top 5 categories are:

Contract Related	58%
Additional Information Required	21%
Eligibility	17%
Coding	2%
Past Filing Deadline	2%

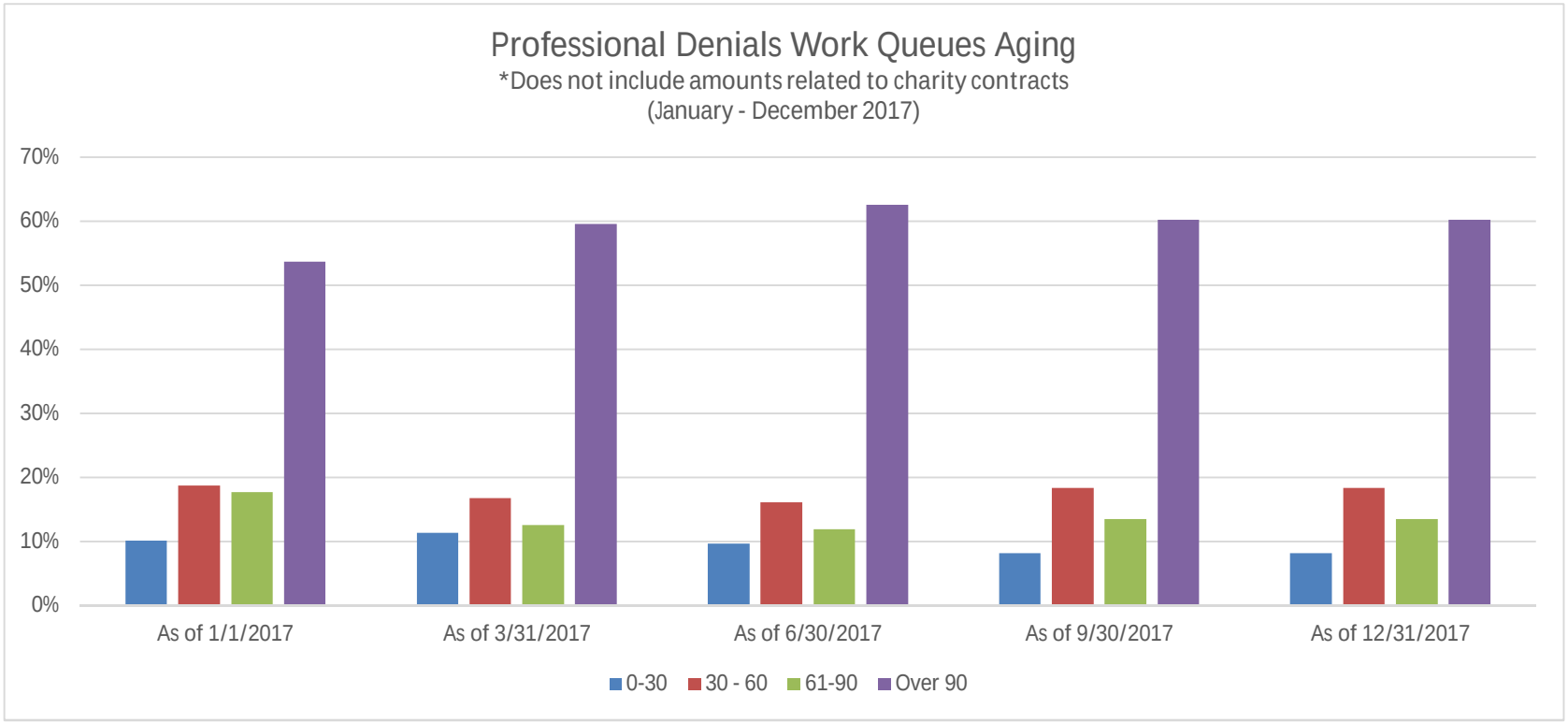
Total Professional denials in calendar 2017 were $80M. The Top 5 categories are:

Eligibility	45%
Contract Related	21%
Coding	14%
Additional Information Required	12%
Past Filing Deadline	7%



Appendix B – Denials Trending

The following graphs detail denial work queue aging as of key dates in 2017 for both hospital and professional groups.



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