OFFICE OF INTERNAL AUDITS
THE UNIVERSITY OF TEXAS AT AUSTIN

1616 Guadalupe St. Suite 2.302 • Austin, Texas 78701 • (512) 471-7117
audit.utexas.edu • internal.audits@austin.utexas.edu

MEMORANDUM

To: Dr. Jay C. Hartzell, President
The University of Texas at Austin

From: Ms. Sandy Jansen, CIA, CCSA, CRMA
Chief Audit Executive

Subject: Dell Medical School Clinical Medical Revenue Cycle Risk Assessment, Project # 23.004

Date: November 30, 2023

To assist leadership with risk management efforts, the Office of Internal Audits (Internal Audits) conducted a risk assessment of Dell Medical School's (DMS) Clinical Medical Revenue Cycle processes. The objectives of the project were to gain an understanding of DMS's clinical revenue cycle landscape and to conduct a risk analysis of revenue cycle operations and compliance, including a review of internal controls. We communicated risk areas to DMS for consideration in strategic and operating decisions, and we plan to use the risk assessment to inform our annual audit planning activities and future audits of the revenue cycle.

The highest risks within DMS's clinical revenue cycle, and additional risks for consideration, are detailed in Appendices 1 and 2, respectively. We did not conduct audit tests to confirm risk mitigation activities or internal controls; however, we considered them in the evaluation of risk likelihood. The highest risks, detailed in Appendix 1, are summarized below.

Insurance Verification
The high frequency of claim denials indicates staff are not consistently verifying insurance eligibility prior to patient arrival, and processes are not configured to identify additional/new insurance coverage in real time. Lack of consistent verification procedures increases the risk of payment delays and coverage denials.

Referrals and Authorizations
There is a high frequency of claim denials because of missing/pending authorizations. Missing authorizations can occur because of inconsistent processes and timelines among departments, misaligned priorities for staff work queues, and limited monitoring of referral resolutions. These gaps increase the risk of patient dissatisfaction, timely access to care, performance of unauthorized procedures, and lost revenue.

Patient Financial Services – Denials
Claims may be denied multiple times because of claim inaccuracies or untimely processing, resulting in delayed or lost revenues. Because DMS has limited monitoring of performance metrics and denial trends, a feedback loop has not been incorporated to improve processes, performance, and denial rates.

Patient Financial Services – Follow-Up
Patient accounts and collections may not be worked timely, resulting in misstated accounts receivable, increased receivable aging, and delayed or missed reimbursements. In addition, lack of timely processes has resulted in an overstatement of receivables because accounts with limited chance of collection are included in the balance.

As DMS continues to expand its clinical operations, management should also consider opportunities to standardize processes across departments, consistently define and utilize data, assess governance approaches, and review organizational structure and staffing needs.

Enclosures:
Appendix 1
Appendix 2

cc: Mr. Timothy Boughal, Senior Compliance Officer, DMS
Dr. C. Martin Harris, Vice President, Health Enterprise and Chief Business Officer, DMS
Mr. Ryan R. Johnson, Chief Operating Officer, UT Academic Health Enterprise, DMS
Dr. Claudi F. Lucchinetti, Senior VP for Medical Affairs and Dean of the DMS
Dr. Michael A. Morrey, Chief Administrative Officer and Chief Healthcare Strategist, DMS
Ms. Christy Sobey, Director of President's Office Operations
Dr. Catherine A. Stacy, Chief of Staff, Office of the Executive VP and Provost
Dr. Sharon L. Wood, Executive Vice President and Provost

APPENDIX 1

Process	Risk Description	Control Type and Description	Understanding of Controls	Probability	Impact
Registration/Admitting - Insurance Verification	Patient insurance coverage has expired, resulting in loss of revenue.	**Automated:** EMR is configured to verify patient and guarantor plan information every 30 days and determine number of days active before it is set to expire. When the status is verified, the system will not prompt users to review the registration information. After the verification duration has expired, registrars know they need to reverify the information prior to patient appointment date.	The frequency of claim denials due to insurance verification indicates there are ongoing errors with staff verifying patient insurance. Athena performs an automatic review of benefits and creates a flag when benefits expire.	High	High
	Insurance/eligibility is not verified prior to patient arrival, resulting in payment delays or non-coverage/eligibility denials.	Monitoring: Patient Access team should set up a Pre-Registration/Insurance Verification work queue to qualify patients with missing insurance verification based on number of days before appointment. It is recommended to verify insurance 1 week ahead and confirm missing information 2-3 days ahead.	The patient access team is not consistently performing verifications previsit (requests via email are sent to the Central Billing Office (CBO) requesting verification be performed which delays the traditional CBO process from occurring).	Medium	Medium
	Insurance/eligibility is not verified prior to patient arrival, resulting in payment delays or non-coverage/eligibility denials.	Monitoring: Set up Kiosk Insurance Verification work queue. Configure Welcome to add patients to a patient work queue when they have no effective coverage or if not all effective coverage was verified for timely resolution per policy. Deficiencies are investigated, and corrective action taken.		Medium	Medium
	Real Time Eligibility (RTE) is not configured to identify additional or new coverages, resulting in payment delays or non-coverage/eligibility denials.	**Automated:** EMR is configured to enable RTE checks for certain Medicare and commercial payers to verify a patient's eligibility when a new coverage is created and/or existing coverage is updated.		Low	Medium

APPENDIX 1 (continued)

Process	Risk Description	Control Type and Description	Understanding of Controls	Probability	Impact
	Insurance verification rate is not part of staff or organization KPIs or regularly monitored by Patient Access Services (PAS) manager, resulting in declines in clinic efficiency.	**Monitoring:** On a monthly basis, Supervisors can use EMR Coverage Verification reports to investigate the number of encounters that were verified by the date of service. This report summarizes the results by revenue location to display percentages of encounters where the member was verified and e-verified. Deficiencies should be reviewed and used as further training for eligibility staff on RTE assistance.	There is no cadence for management to review KPIs related to insurance verification. There is a current breakdown in responsible party and cadence of performing insurance verifications previsit.	Medium	Medium
Registration/Admitting - Insurance Verification	RTE is not configured to capture correct patient information, resulting in payment delays or non-coverage/eligibility denials.	**Automated:** Configure RTE outgoing and incoming messages and specify level of information returned using search paths at the interface, benefit plan, payer, or system levels.	The frequency of claim denials due to insurance verification indicates there are ongoing errors with staff verifying patient insurance. Insurance verification is initially performed within Athena, and external sites are used when this function is not available.	Low	Medium
	RTE is not configured to capture correct patient information, resulting in payment delays or non-coverage/eligibility denials.	**Monitoring:** Utilize EMR Eligibility Check-up dashboard to review incoming message data. PAS and IT supervisors will coordinate quarterly reviews to extract information on eligibility response to build/update payer or plan mapping tables. Deficiencies should be reviewed and corrected on a monthly basis.		Low	Medium
Outpatient Access - Referrals/Authorizations	If preauthorization notification is not provided to the scheduler, non-authorized procedures may be performed leading to impacts on department revenue.	**Automated:** For out-of-network patients, if preauthorization is required, a warning message will appear so the scheduler can notify the patient that the service is out-of-network.	There is a high frequency of claim denials due to referrals/authorizations versus the current processes reported by UT staff. The discrepancy in denials versus process is an opportunity to further review.	High	Medium
	Staff work queues are not monitored for timely resolutions on pending physician-to-physician referrals, leading to patient dissatisfaction and declines in clinic efficiency.	**Monitoring:** On a weekly basis, various clinical departments review the EMR Referral Productivity report to confirm open referrals are being followed up or obtained in a timely manner per policy. Deficiencies are investigated, and corrective action taken with responsible parties (e.g., internal/external departments, patient).		Medium	Medium

APPENDIX 1 (continued)

Process	Risk Description	Control Type and Description	Understanding of Controls	Probability	Impact
Registration/Admitting - Referrals/Authorizations	Authorization number is not entered correctly, resulting in system error or no authorization denials.	**Interface:** Interface Experian Real Time Authorization (RTA) to EMR to automatically populate Experian authorization numbers to the EMR authorization number field.	There is a high frequency of claim denials due to referrals/authorizations versus the current processes reported by UT staff. The discrepancy in denials versus process is an opportunity to further review.	Medium	High
	Missing authorizations are not prioritized and escalated for resolution, resulting in untimely defer/reschedule appointment decisions.	Policy: Implement standardization around account prioritization. Determine how staff will filter/sort through work queues to identify priority accounts and how the authorization status field will be used to identify accounts where authorization is pending/missing.		Medium	Medium
gistration/Admitting - Referrals/Authorizations	Preauthorization/Precertification management may not be centralized across all departments, which negatively impacts provider productivity, access to care, continuity of care, and patient safety.	**Policy:** Create policy and procedures around a standardized preauthorization management system (centralized or decentralized model) for all services requiring authorization.		High	Medium
	Accounts pending authorizations within staff worklists/work queues are not properly worked to obtain, record, or complete authorization or precertification for a patient's direct admission to the hospital, resulting in patient dissatisfaction and declines in clinic efficiency.	Monitoring: On a daily basis, the Financial Clearance Center (FCC) supervisor monitors the Auth/Cert Admissions work queues to verify that preauthorizations or precertifications were obtained from the insurance company before the patient was admitted or service was performed per policy. Deficiencies are investigated, and corrective action taken with the responsible Auth/Cert staff member.		Medium	Medium
	Accounts pending insurance authorizations are not set up chronologically by date of service, resulting in untimely authorization collection.	Monitoring: Authorization work queues can be set up by service-rendering departments. Authorization coordinators can sort the work queue in descending order by scheduled appointment dates to prioritize accounts with missing prior authorization (i.e., 14 days out, 7 days out, 2-3 days out).		Medium	Medium

APPENDIX 1 (continued)

Process	Risk Description	Control Type and Description	Understanding of Controls	Probability	Impact
Re	Authorization is not obtained prior to patient visits, resulting in no authorization delays or no authorization denials.	Automated: Configure EMR to route appointments with procedures that require authorization to Referral/Authorization work queues. Build system-level configurations to evaluate if the procedure automatically qualifies to "Needs Authorization work queue" based on preauthorization check of procedures (i.e., MRIs, CTs) or settings in payer/plan record.		Medium	Medium
Registration/Admitting - Referrals/Authorizations	Individual assignments or department restrictions in referral work queue settings are not set up correctly, resulting in patient dissatisfaction and declines in clinic efficiency.	Application Security: Configure user access so the appropriate end users have access to work queues based on service area and login department. Allow users who should have increased level of security to access referral and authorization work queues, edit/update field records, and defer a referral.		Medium	Medium
	If orders are not set up to require preauthorization in EMR, end users will not be prompted to obtain preauthorization, resulting in denials and loss of revenue.	**Automated:** Configure preauthorization requirements at the system definitions level. If applicable, configure payer plan exceptions.		Low	Medium
	Inconsistent authorization processes and timelines across facilities result in claim denials.	**Policy:** Implement preauthorization policy and procedures to ensure compliance around delay/deny of patient appointments when authorization is not obtained. Define urgent, emergent, and elective appointments to escalate certain patient appointment statuses to the Order Department, then the Order Department or Call Center will initiate patient contact to reschedule.	Current procedures allow patients to be scheduled though no authorization has been received.	Medium	Medium

APPENDIX 1 (continued)

Process	Risk Description	Control Type and Description	Understanding of Controls	Probability	Impact
PFS - Denials	Claim denials or appeals not processed accurately results in further denials and lost revenue.	**Monitoring:** On a monthly basis, the Hospital Billing (HB) and Professional Billing (PB) Denials supervisor reviews the HB Insurance and Denials dashboard and the PB Insurance Follow-up Supervisor dashboard to verify that denied claims are resolved in a timely manner. Inaccurate or incomplete deficiencies are investigated, and corrective action is taken.	There is a high frequency of claim denials for initial and resubmitted claims, which includes dollar amounts by denial reason. There is an increased amount of denials for resubmitted claims, and in some instances, the same claim is denied a number of times. There are currently no standing meetings to review work processes with staff to ensure accuracy of appeals.	High	High
	Claim denials or appeals not processed timely results in lost revenue.	Monitoring: EMR is configured to route payer denied claims by reason codes to the HB or PB Denials Account Work Queues for timely follow-up and resolution. Owning area and status could be utilized to directly route accounts to teams outside of denials (e.g., coding). Ensure team members document the appropriate denial records with root cause, source area, and notes for reporting purposes.	There is a high frequency of claim denials upon resubmission of the claim for appeal. Staff work queues are prioritized by highest dollar and oldest claim; however, denials are included in this work queue and are not prioritized over claims for initial submission.	High	High
PFS - Denials	Unclear accountability results in delayed resolution of denials or revenue loss.	**Policy:** Establish policy that outlines turn around times for denials worked by owning areas and escalation paths, including payer escalations, to ensure timely resolution of denials.		Medium	High
	Not monitoring and tracking denial trends results in subsequent denials and missed opportunities for process and performance improvement.	**Monitoring:** On a monthly basis, the Denials Prevention Committee reviews HB and PB Denials data (e.g., Insurance and Denials dashboard, Slicer Dicer reports and Denials Cube) to review trends by owning area. Root cause analysis is performed on identified trends, corrective action plans are developed, and/or retraining is conducted as necessary. Evidence of review is documented and retained.	There is a high frequency of claim denials for initial and resubmitted claims, which includes dollar amounts by denial reason. There are currently no standing meetings to review KPIs related to denial tracking and corrective action plans.	High	Medium

APPENDIX 1 (continued)

Process	Risk Description	Control Type and Description	Understanding of Controls	Probability	Impact
	Not monitoring and tracking denial trends results in subsequent denials and missed opportunities for process and performance improvement.	**Monitoring:** On a monthly basis, the HB and PB Denials managers review the PB Write-off Review report and the HB Denials and Insurance dashboard to review write-off trends by owning area. Root cause analysis is performed on identified trends, corrective action plans are developed, and/or retraining is conducted as necessary. Payer trends are escalated to the appropriate stakeholders. Evidence of review is documented and retained.		High	Medium
S - Follow Up	Bad debt accounts are not flagged timely, resulting in open or aged A/R.	**Automated:** EMR is configured to add an outsource flag for all self-pay accounts that qualify for agency follow-up as per department policy.	There are a number of claims within A/R that exceed 365 days that have not been written off to bad debt. The A/R data is currently overstated and includes accounts that have a low chance of collection. These have not been written off due to the high amount of unposted dollars that may include these old claims.	High	High
	Incorrect adjustments and refunds results in rework and understated/overstated A/R.	**Policy:** Establish policies with threshold amounts and set security controls to restrict supervisors, managers, directors, etc. from exceeding limits for write offs, adjustments, and refunds.	There are a number of claims within A/R that exceed 365 days that have not been written off to bad debt. There are no adjustment limits for A/R staff, and write offs are reviewed with management on a case-by-case basis via audit of steps performed.	High	High
	Accounts not worked accurately and timely results in delayed or lost reimbursement.	Monitoring: On a monthly basis, the HB and PB follow-up supervisors select a sample of completed insurance follow-ups from the EMR Follow-up Work Queue Activity Summary report and review the accounts and invoices for accuracy, completeness, and validity. Deficiencies are investigated, and corrective action is taken.	A/R is skewed towards claims over 121 days, while claims sit in A/R for an average of 49 days. Audits on staff accuracy are not performed until there is a specific write-off request. At this time, management will review the entirety of the account for accuracy and correct step-by-step procedures.	High	High

APPENDIX 1 (continued)

Process	Risk Description	Control Type and Description	Understanding of Controls	Probability	Impact
PF	Outstanding account receivables that are not monitored on a regular basis leads to delayed or lost reimbursements.	**Monitoring:** On a monthly basis, the HB and PB manager reviews accounts that remain outstanding on the Aged A/R by provider, financial class, and payer report and the PB Aged A/R report. Aged accounts with no activity within 45 days are reviewed to confirm recent follow-up activity has been performed. Deficiencies are investigated, and corrective action is taken.	There are a number of claims within A/R that exceed 365 days that have not been written off to bad debt. The A/R data is currently overstated and includes accounts that have a low chance of collection. Audits on staff accuracy are not performed until there is a specific write-off request. At this time, management will review the entirety of the account for accuracy and correct step-by-step procedures.	High	High
	Accounts not worked timely results in aged A/R ultimately leading to adjustments and revenue loss.	Monitoring: On a weekly basis, the Single Billing Office (SBO) supervisor monitors the SBO Self-Pay Follow-up work queues and reviews the SBO Self-Pay work queue monitoring report to verify that self-pay follow-ups are resolved in a timely manner per policy. Deficiencies are investigated, and corrective action is taken.		High	High
PFS - Follow Up	Insurance collections not pursued timely result in delayed reimbursement and aging of accounts.	Monitoring: On a weekly basis, the HB or PB Follow-up supervisor reviews the EMR Insurance Follow-up Work Queue Needing Attention report and/or the EMR PB or HB No Response work queues to verify insurance follow-up items are addressed and resolved in a timely manner. Deficiencies are investigated, and corrective action is taken.		High	High
	Bad debt accounts are not sent to vendors periodically for resolution, resulting in open and aged A/R.	**Automated:** EMR is configured to send daily placement files to the bad debt agency vendor utilizing the configuration settings, output frequency, and day of the week fields. EMR has a standard collection file format (extension 63296) that should be used to set up the file format.		High	Medium

APPENDIX 1 (continued)

Process	Risk Description	Control Type and Description	Understanding of Controls	Probability	Impact
	Insurance collections not timely pursued results in delayed reimbursement and aging of accounts.	Monitoring: EMR is configured to route claims requiring insurance follow-up to the HB and PB Insurance Follow-up work queues or HB and PB No Response work queues based on remittance code and payer for timely resolution. Deficiencies are investigated, and corrective action taken.		High	Medium

APPENDIX 2

Process	Risk Description	Control Type and Description	Understanding of Processes and Controls
Outpatient Access - Scheduling	Lack of standardization of Schedule Order Work Queues leads to patient access barriers, referring provider dissatisfaction, and declines in clinic efficiency.	**Monitoring:** Use the Schedule Orders work queues daily to monitor procedures that need scheduling and follow up for timely resolution per policy.	New patients must register by phone and established patients may use the phone or patient portal to request new appointments. Calls are directed to the call center. External scheduling sites are not used.
	Lack of standardization of schedules and scheduling workflows for providers leads to patient access barriers, referring provider dissatisfaction, and declines in clinic efficiency.	**Automated:** Utilize EHR functionality to standardize the scheduling workflow for each visit type (i.e., primary care, specialty, procedural, and diagnostic areas) and department carve-outs for special procedures (i.e., urgent, emergent, and elective procedures).	
	Patients are unable to request appointments on the waitlist within MyChart, resulting in scheduling inefficiency and patient dissatisfaction.	**Automated:** Create rules to exclude certain appointments from being automatically added to the waitlist from MyChart Fast Pass (i.e., therapy plans, recurring, group, and inpatient appointments).	
	Physician-to-physician referrals are not completed timely, resulting in delayed/missed diagnoses and inadequate treatment.	**Automated:** Limit the time frame which a user has to complete or defer a physician-to-physician referral within Physician-to-Physician Referral work queues by choosing a maximum deferral date for referral work queues. Require a deferral reason when users choose to defer.	
	Physician-to-physician referral management is not centralized across all departments, which negatively impacts provider productivity, access to care, continuity of care, and patient safety.	**Policy:** Create a policy and procedures document around a standardized system for physician-to-physician referrals for services (centralized or decentralized model) for all departments.	A referral box is utilized and handled by the call center. The referral process is centralized and decentralized, as the call center utilizes referral coordinators while some clinics have their own.
	Schedulers manually flag referrals in the system, resulting in missed or incorrect referral assignments.	**Automated:** The scheduling status of a referral can be automatically assigned to a referral and patient work queue. The EHR can assign scheduling status (e.g., External-Ready to Schedule) based on the configuration of referral status, visit counts, referral type, and current scheduling status and rules.	

APPENDIX 2 (continued)

Process	Risk Description	Control Type and Description	Understanding of Processes and Controls
Outpatient Access - Scheduling	Scheduling worklist/work queues are not monitored for weekly volume consumption, resulting in lack of visibility into volumes and user activity/productivity.	**Monitoring:** On a weekly basis, the Patient Access supervisor/manager reviews the Supervisor Dashboard and/or the Centralized Scheduler Dashboard for schedule orders work queue volumes (e.g., deferring, removing and/or adjusting scheduling orders) to determine if additional training or changes to the work queue build are needed. Deficiencies are investigated, and corrective action taken.	KPIs are not actively reviewed.
HIM Coding - Coding	Accounts not coded timely by team members result in unnecessary backlog of accounts, delaying reimbursement.	**Automated:** EMR is configured with a productivity clock that tracks coders productivity when account status is "In Progress." Reopening and completing an account automatically restarts the productivity clock.	Lag time between Date of Service (DOS) to claim created date is well above benchmarks. Further investigation into the cause is needed. KPIs are not reviewed, and work queues are only audited during write-off reviews.
	Delays in coding accounts result in prolonged reimbursements or untimely filing of related denials.	**Monitoring:** EMR is configured to automatically route accounts with complete documentation (e.g., complete H&P Note, Discharge Summary Note or Op Note) to the Health Information Management (HIM) Outpatient Recurring Accounts work queues during nightly batch processing.	
	Providers may not complete clinical documentation in a timely manner, delaying coding and subsequent reimbursement.	**Monitoring:** EMR is configured to automatically route accounts awaiting provider review or response to a query to the Physician Query work queues for timely resolution per policy.	
	Providers may not respond to queries in a timely manner, delaying coding and billing.	**Monitoring:** On a daily basis, the CDI (Clinical Documentation Improvement) specialist reviews the HIM CDI Manager Overview dashboard to ensure that HIM CDI Worklists are worked in a timely manner. Physician queries identified as unanswered are investigated, and corrective action is taken.	
	Providers may not complete clinical documentation in a timely manner, delaying coding and subsequent reimbursement.	**Monitoring:** On a weekly basis, the lead CDI staff reviews the EMR Outstanding Queries worklist to identify physicians who have not responded to coding and documentation queries. Unresolved queries are investigated, and follow up occurs with physicians per policy.	

APPENDIX 2 (continued)

Process	Risk Description	Control Type and Description	Understanding of Processes and Controls
HIM Coding - Coding	Lack of accountability for monitoring work queues/work lists (e.g., registration, referral, charge, and coding) results in prolonged billing.	**Policy:** Establish policies for work queue accountability and response times. This includes setting productivity and quality assurance standards for coders.	
	Clinical documentation does not support billing and/or medical records are incomplete, prolonging reimbursements.	**Monitoring:** EMR is configured to route the physician's response back to the HIM CDI work queues for CDI specialist review and determination of whether the documentation is complete for timely resolution per policy.	Coding, additional documentation required, and medical policy issues are the top three reasons for claim denials. This is also the case for second pass denials, meaning there are issues within the process of claim resubmission. Though process interviews did not include coding, further investigation should be performed.
	Clinical documentation does not support billing and/or medical records are incomplete, prolonging reimbursements.	**Monitoring:** EMR is configured to route all accounts to the HIM CDI worklists for review of documentation by the CDI specialist for timely resolution per policy.	
	Coding and claims errors are not resolved timely and/or coding updates are not recorded or not recorded timely, resulting in delayed billing or coding related denials.	**Monitoring:** EMR is configured to route accounts identified by coders needing additional review to the HIM Coding Manager Review Needed work queues for timely resolution per policy.	
	Coding updates are not recorded or errors are not resolved timely, resulting in delayed billing or coding related denials.	**Monitoring:** EMR is configured to identify coding errors and route the account to the appropriate Coding work queues for review and timely resolution by the Coding team per policy.	
	Inaccurate and untimely coding results in delayed or lost reimbursement.	**Monitoring:** On a daily basis, HIM Coding supervisors (or equivalent) review the EMR HIM Uncoded Outpatient Accounts reports to verify uncoded accounts are completed in a timely manner. Deficiencies are investigated, and corrective action taken.	
	Inaccurate and untimely coding results in delayed or lost reimbursement.	**Monitoring:** On a weekly basis, the HIM coding manager (or equivalent) reviews the HIM coding manager review work queues to monitor coding updates performed by the HIM coder and verify DNB warnings and errors are resolved in a timely manner (i.e., 24 hours). Deficiencies are investigated, and corrective action taken.	
	Inaccurate use of modifiers results in bundling related denials and underpayments.	**Automated:** EMR is configured to allow selection from a predefined list of active CPT code modifiers.	

APPENDIX 2 (continued)

Process	Risk Description	Control Type and Description	Understanding of Processes and Controls
HIM Coding - Coding	Coding updates and errors are not recorded and resolved timely, resulting in coding related denials.	**Monitoring:** EMR is configured with Simple Visit Coding (SVC) Validation Checks to identify coding deficiencies for simple visits (e.g., physical therapy, occupational therapy, speech therapy), which are routed to the SVC Error work queues for timely resolution per policy.	
	Coding errors are not monitored or resolved in a timely basis, resulting in delayed or lost reimbursement.	**Monitoring:** On a monthly basis, the HIM Coding manager monitors the EMR HIM SVC Errors and Completion report to track errors and verify that coders are correcting the errors in a timely manner. Deficiencies are investigated, and corrective action taken.	
Billing Compliance - Clinical Documentation Standards	Coders/physicians submitting charges that are not supported by notes leads to noncompliant billing.	**Monitoring:** On an annual basis, Billing Compliance audits a sample of charts for each provider to review provider and coder accuracy and provide training/feedback regarding discrepancies found in coding and incomplete documentation.	Coding, additional documentation required, and medical policy issues are the top three reasons for claim denials. Though process interviews did not include coding, further investigation should be performed.
	Inappropriate amendment of medical records after records are complete leads to noncompliant billing.	**Policy:** A policy exists that clearly defines the amendment periods for medical records across various settings (e.g., outpatient surgeries lock at 30 days).	There is a high frequency of claim denials due to coding, medical policy, and additional documentation being required. AAPC certified coders have autonomy to amend billing codes if, based on clinical notes, an incorrect code was selected by the provider. Providers have 30 days to add addendums to their notes.
	Inappropriate amendment of medical records after records are complete leads to noncompliant billing.	**Automated:** EMR is configured to notify the encounter provider via an Addendum In Basket message when the addendum was not entered by the encounter provider.	
	Inappropriate amendment of medical records after records are complete leads to noncompliant billing.	**Automated:** Outpatient surgery charts lock at 30 days at which point providers will no longer be able to document within EMR and requests will need to be taken to the EMR Committee.	