TEXAS
The University of Texas at Austin

Dell Medical School

Revenue Cycle

April 2025

Office of Internal Audits
UT Austin's Agents of Change

Executive Summary

Dell Medical School

Revenue Cycle
Project Number: 24.007

Audit Objective

The objectives of this audit were to determine whether insurance verification processes are effective in ensuring verification prior to patient service and to identify improvement opportunities to be considered for current processes and as Dell Medical School (DMS) prepares for a new electronic health record (EHR) implementation.

Conclusion

The insurance verification processes are generally effective. However, verification processes are primarily manual because of system limitations with the current EHR, which is increasingly unable to efficiently manage the volume of patients and complexity of clinics at UT Health Austin (UTHA).

Background

Effective medical insurance verification processes are crucial for healthcare organizations, as they reduce the risk of claim denials or delays in reimbursement and improve patient trust and satisfaction. UTHA has two teams that collaborate to verify a patient's insurance coverage, the Patient Access Center team and the Revenue Cycle team. Staff in these departments collect and verify demographic information and insurance/referral details and confirm that specific procedures are covered.

Since UTHA's opening in 2017 with three specialty clinics, it has experienced increased patient volume, claims, and revenue, necessitating an improved EHR to meet patient and provider needs. The following table demonstrates UTHA's growth during the scope period of this audit.

UTHA	FY23	FY24	Increase
Scheduled Appointments	85,693	96,817	12.98%
Total Claims	99,159	112,804	13.76%
Total Revenue	$15,414,828	$18,975,363	23.10%
Total Patients	28,517	30,998	8.70%

Audit Observations

No recommendations were provided. See Process Improvement Considerations.

Process Improvement Considerations

As DMS transitions to a new EHR system, leadership should consider the following process improvements:

- Require clinical staff to direct all patient scheduling to the Health Access Partners (HAPs) in the UTHA Access Center. Prior to scheduling the appointment, HAPs verify that the patient's insurance is in-network, that the provider is enrolled, and perform an initial electronic insurance verification through the EHR. Scheduling by clinical staff circumvents this process, increasing the burden on the Benefits Eligibility team and the likelihood of non-payment due to ineligibility.
- Ensure that documented processes and procedures are aligned and standardized. Disparate operating procedures between the Access Center and Revenue Cycle teams could impede collaboration and coordination in the implementation of new insurance verification processes.
- Configure decision trees within the new EHR to reduce reliance on spreadsheets. This change could improve efficiency and reduce human error in the scheduling and benefits eligibility process.
- Identify, evaluate, and monitor key insurance verification performance indicators to better inform management of process effectiveness and improvement opportunities.

Scope, Objectives and Methodology

This audit was conducted in conformance with The Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing*. Additionally, we conducted the audit in accordance with Generally Accepted Government Auditing Standards and meet the independence requirements for internal auditors. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions on our audit objectives.

The scope of this review included FY23 and FY24 patient appointments and current insurance verification procedures.

Table: Objectives and Methodology

Audit Objective	Methodology
Determine whether insurance verification processes are effective in ensuring verification prior to patient service.	• Examined policies, procedures and workflows. • Conducted walkthroughs and interviews with Access Center and Revenue Cycle staff. • Tested a sample of scheduled patients for timing, accuracy, completion and denials.

Identify process improvement opportunities to be considered for current processes and as DMS prepares for a new EHR implementation	• Mapped the insurance verification processes. • Reviewed revenue cycle management best practices and identified process improvements.

Engagement Team

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Report Submission

We appreciate the courtesy and cooperation extended throughout the audit.

Respectfully Submitted,

Sandy Jansen, CIA, CCSA, CRMA, Chief Audit Executive

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