

UTSouthwestern
Medical Center™

Office of Institutional Compliance
and Audit Services

Revenue Cycle Compliance Advisory Audit

Internal Audit Report 26-AS-1418

January 16, 2026



Executive Summary

The University of Texas Southwestern Medical Center’s (UT Southwestern) Health System Compliance (HSC) unit operates within the institution’s compliance department and collaborates with ambulatory and hospital operations to identify risk vulnerabilities and implement mitigation strategies that ensure adherence to applicable laws and regulations. A key compliance function, performed in response to requests from operations and management, involves issuing compliance advisories related to revenue-cycle coding and billing. There has been a high volume of compliance advisories requested, developed, and issued each quarter, involving multiple departments and processes; however, it remains unclear how effective these outputs are and to what extent the advisories are being followed. Given the need for strict adherence to regulatory and institutional standards, inefficiencies within this workflow can elevate risk for UT Southwestern.

Engagement Results

The Office of Institutional Compliance and Audit Services (OICAS) conducted an internal audit of the HSC advisory function, focusing on processes in place and advisories issued during the period March 2025 through September 2025.

The audit team identified several key strengths that support operational efficiency and regulatory compliance, including:

- Delivery of well-researched, evidence-based guidance
- Prompt recording of advisory requests in the SAI database for internal tracking
- Reinforcement of verbal guidance through written communication

Opportunities for improvement include enhancing formal documentation, streamlining workflows to reduce response delays, and implementing robust post-issuance monitoring. Addressing these areas will improve efficiency, support timely responses, and reduce the risk of non-compliance, misinterpretation and billing errors.

A summary of observations is outlined below:

AREA	OPPORTUNITIES	RISK RATING
Regulatory Oversight	<ul style="list-style-type: none"> • Regulatory Change Management 	MEDIUM
Standardized Compliance Advisory Workflow	<ul style="list-style-type: none"> • Standardized Workflow & Responses • Advisory Triage & Risk Prioritization 	MEDIUM

AREA	OPPORTUNITIES	RISK RATING
	<ul style="list-style-type: none"> • Intake Process • Key Performance Indicators 	
Institutional Advisory Visibility	<ul style="list-style-type: none"> • Compliance Advisory Repository 	MEDIUM
Implementation Validation Process	<ul style="list-style-type: none"> • Advisory Implementation Monitoring 	MEDIUM

Further details are outlined in the Detailed Observations section. Less significant issues were communicated to management.

Management Response Summary

Management agrees with the observations and recommendations and has developed action plans to be implemented on or before August 31, 2026.

Appendix A outlines the objective, scope, methodology, stakeholder list, and audit team for the engagement.

Appendix B outlines the Risk Rating Classifications and Definitions.

The audit team appreciates the courtesy and cooperation from the personnel in HSC and the Revenue Cycle department throughout the engagement.

Natalie A. Ramello

Natalie A. Ramello, JD, CIA, CHC, CHPC, CHRC, CHIAP
Vice President, Chief Compliance and Audit Officer
Office of Institutional Compliance & Audit Services
January 16, 2026

DETAILED OBSERVATIONS

1. Regulatory Oversight

UT Southwestern lacks a centralized regulatory oversight function, placing a reactive burden on the Compliance team and individual departments. This fragmented approach increases the risk of inconsistent compliance and potential legal, financial, or reputational consequences.

MEDIUM

1.1 Regulatory Change Management

Recommendations

Management Action Plan

UT Southwestern does not have a centralized office dedicated to monitoring, interpreting, and disseminating regulatory changes. In the absence of such a function, the HSC team has been informally relied upon providing regulatory guidance on a reactive, request-driven basis. This ad hoc approach limits proactive outreach, contributes to inconsistent awareness of regulatory obligations, and places an unsustainable burden on the Compliance team to address inquiries outside a structured framework.

The absence of centralized regulatory oversight increases the burden on individual departments to independently interpret and implement regulatory changes, leading to inconsistent compliance practices. This fragmentation heightens the risk of reputational damage, financial penalties, and legal exposure if regulatory obligations are misunderstood or inadequately addressed across the institution.

Management should consider establishing a centralized regulatory affairs office or designating a formal function within an existing department to:

- Monitor and interpret relevant regulatory changes
- Develop and distribute timely guidance and educational materials
- Serve as a liaison between regulatory bodies and institutional stakeholders. This will reduce reliance on ad hoc compliance support and enhance institutional readiness and accountability.

Action Plan Owner:
Angela Magee

Action Plan Executive:
TBD

Due Date: 8/31/2026

Management will determine feasibility of creating a centralized regulatory office or designated role within an existing department such as HSC to monitor and interpret regulatory changes across UT Southwestern and implement change management where appropriate.

If establishing a dedicated department or position for institution-wide regulatory affairs is not feasible, management will designate a responsible department for health system regulatory change management and implement standardized procedures to proactively communicate and educate relevant stakeholders on regulatory updates in this area.

2. Standardized Compliance Advisory Workflow

The HSC team has demonstrated strong responsiveness to a high volume of advisory requests; however, the absence of a standardized workflow and triage structure limits consistency, clarity, and efficiency. This increases the risk of misaligned guidance, delays in addressing high-priority issues, and added strain on compliance resources. Additionally, the advisory response process is not consistently aligned with established performance expectations, resulting in variable prioritization, delayed turnaround times, and challenges in consistently meeting advisory commitments.

MEDIUM

2.1 Standardized Workflow & Responses	Recommendations	Management Action Plan
<p>The HSC team does not utilize a standardized workflow or structured format for responding to advisory requests. Advisory responses varied in format and content.</p> <p>Without a standardized workflow, advisory responses from the HSC team vary in format, clarity, and regulatory accuracy. This inconsistency can confuse stakeholders, undermine trust in guidance, and limit the institution’s ability to track, learn from, and improve compliance practices, ultimately increasing the risk of regulatory misinterpretation.</p>	<p>Management should develop a structured response approach using a standardized template to ensure each advisory is clear, evidence-based, and directly addresses the request. Responses should be delivered as templated documents rather than embedded in email bodies to enhance clarity and traceability.</p> <p>Consider using AI-enabled systems to assist with drafting responses, validating regulatory references, and flagging missing elements. This can improve consistency, reduce turnaround time, and support regulatory accuracy.</p>	<p>Action Plan Owners: Angela Magee Shekeya McCallister Patricia Adkins</p> <p>Action Plan Executive: TBD</p> <p>Due Date: 3/31/2026</p> <p>Management will:</p> <ul style="list-style-type: none"> Develop and implement a standardized advisory template that includes required sections such as the request summary, date, regulatory basis, and recommendations, ensuring that each advisory serves as a stand-alone reference document. Utilize technology support to assist with drafting responses. Maintain requirements for formal review and approval by the Director of HSC or designee before issuance.

2.2 Advisory Triage & Risk Prioritization	Recommendations	Management Action Plan
<p>The HSC team lacks a standardized process for triaging advisory requests, assigning risk levels, and determining when to refer inquiries to other departments. Inconsistent prioritization of advisory requests, along with instances where responses extended beyond the HSC team’s scope, has added unnecessary strain on the team, highlighting the need for structured triage and referral processes to better manage workload and ensure appropriate handling of complex issues.</p> <p>The absence of a structured advisory process places added strain on the HSC team, leading to inefficiencies in handling requests. Without defined criteria for triage and escalation, resources may be misallocated, delaying attention to critical issues while overcommitting to lower-risk matters. This can impact the effectiveness and responsiveness of compliance operations.</p>	<p>Management should:</p> <ul style="list-style-type: none"> • Establish and implement a standardized advisory workflow that includes clear triage protocols, consistent risk ranking criteria, and defined referral pathways to appropriate departments • Develop a decision algorithm to help team members consistently prioritize and route requests, improving efficiency and reducing burden on the HSC team. 	<p>Action Plan Owner: Angela Magee</p> <p>Action Plan Executive: TBD</p> <p>Due Date: 4/30/2026</p> <p><i>Management will:</i></p> <ul style="list-style-type: none"> • <i>Develop and implement a formal HSC advisory workflow with risk-based triage to prioritize and route requests efficiently.</i> • <i>Embed a decision algorithm within the advisory workflow to guide team members from intake through disposition. The algorithm might include documented referral pathways with owners, response time expectations, and feedback loops to confirm handoffs.</i> • <i>Provide training to compliance staff on the newly established workflow and decision algorithm to ensure consistent understanding and application.</i>
2.3 Intake Process	Recommendations	Management Action Plan
<p>The HSC team does not currently utilize a standardized intake process for advisory requests, resulting in inconsistent submission methods and frequent back-and-forth to</p>	<p>Implement a standardized advisory intake process using a centralized platform such as Microsoft Forms, ServiceNow, or a similar application. This will ensure consistent data</p>	<p>Action Plan Owners: Angela Magee Shekeya McCallister Patricia Adkins</p>

<p>clarify request details. Requests are received through various channels, including the compliance email inbox, meetings, and informal interactions, which increases administrative burden and complicates tracking.</p> <p>Additionally, there is a pattern of revenue cycle teams routing inquiries to Compliance that may be more appropriately addressed by other departments, further straining resources and delaying resolution. This lack of structure limits efficiency, impedes prioritization, and increases the risk of misrouted or incomplete responses.</p>	<p>capture, reduce back-and-forth clarification, and enable better triage of requests to the appropriate team.</p>	<p>Action Plan Executive: TBD</p> <p>Due Date: 4/30/2026</p> <p><i>Management will:</i></p> <ul style="list-style-type: none"> • <i>Revise the existing centralized intake form and reinforce the use of the form.</i> • <i>Embed the intake process into the standardized Compliance Advisory workflow and document in a formal SOP. Conduct training on the intake process for the HSC team.</i> • <i>Re-educate the key stakeholders, including revenue cycle teams and other frequent requesters, about this process.</i>
2.4 Key Performance Indicators	Recommendations	Management Action Plan
<p>The HSC team’s advisory response process lacks alignment with established performance expectations, including the 7-14 day turnaround KPI. Advisory prioritization levels were applied inconsistently, contributing to delays and variability in response delivery. These gaps reduce efficiency, delay resolution of critical issues, and limit accountability in advisory operations.</p>	<p>Implement a formal KPI monitoring process that includes a system to track advisory responses, and address those not meeting expected time frames.</p> <p>Clarify team responsibilities and implement role-based review process (based on staff expertise) to improve accountability, reduce duplication of effort, and enhance the quality and consistency of advisory responses.</p>	<p>Action Plan Owner: Angela Magee</p> <p>Action Plan Executive: TBD</p> <p>Due Date: 5/31/2026</p> <p><i>Management will:</i></p> <ul style="list-style-type: none"> • <i>Revise the current turnaround time KPI to reflect tiered expectations aligned with advisory risk levels.</i> • <i>Develop a KPI dashboard to provide real-time visibility into advisory</i>

		<p><i>response times, monitor progress, identify delays, and intervene promptly when cases exceed expected timeframes.</i></p> <ul style="list-style-type: none"> • <i>Review dashboard data regularly to identify trends, address bottlenecks, and refine processes as needed.</i>
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3. Institutional Advisory Visibility

Advisory responses from the HSC team are currently delivered directly to individual requestors, which limits visibility across departments and reduces opportunities for broader institutional learning. In the absence of a centralized, searchable repository, staff may be unable to access prior guidance, resulting in duplicate requests, repeated effort, and inefficiencies in response delivery.

MEDIUM

3.1 Compliance Advisory Repository	Recommendations	Management Action Plan
<p>Advisory responses from the HSC team are delivered directly to individual requestors, limiting visibility across departments and missing opportunities for broader institutional benefit.</p> <p>The absence of a centralized repository prevents staff from accessing previously issued guidance, leading to duplicate requests, repeated work, and inefficiencies in response delivery. Without a searchable archive, the Compliance team cannot easily reference prior advisories, and stakeholders often rely on informal email trails to locate past answers.</p>	<p>Develop a centralized, searchable repository for compliance advisory responses to promote transparency, reduce duplication of effort, and enhance institutional knowledge sharing.</p> <p>The repository should provide revenue cycle, departments, and providers with access to prior guidance, while enabling the HSC team to efficiently reference past advisories and deliver more consistent, scalable support across the institution.</p>	<p>Action Plan Owners: Angela Magee Shekeya McCallister Patricia Adkins</p> <p>Action Plan Executive: TBD</p> <p>Due Date: 5/31/2026</p> <p><i>Management will:</i></p> <ul style="list-style-type: none"> • <i>Design and implement a secure, searchable repository that serves as the single source of truth for issued compliance advisories.</i> • <i>Train compliance staff on repository use, including uploading advisories and applying metadata tags. Review</i>

		<p><i>repository usage and solicit feedback from stakeholders to identify enhancements.</i></p>
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4. Implementation Validation Process

The HSC team does not currently conduct post-implementation monitoring to confirm whether advisory guidance is understood and applied as intended, and available tools such as Epic Slicer-Dicer and data analytics are not actively used to support this process. Without follow-up, opportunities to identify implementation challenges, reinforce correct practices, and support continuous improvement may be missed.

MEDIUM

4.1 Advisory Implementation Monitoring	Recommendations	Management Action Plan
<p>The HSC team does not currently conduct post-implementation follow-up to verify whether advisory guidance is implemented as recommended. Additionally, the Compliance team does not leverage available tools, such as Epic Slicer Dicer or data analytics, to monitor compliance with issued advisories.</p> <p>One (1) advisory tested during the audit identified that the receiving department had misunderstood the guidance and continued to code incorrectly until the issue was identified through audit inquiries. This highlights the need for post-advisory follow-up to confirm understanding and proper implementation of compliance recommendations.</p> <p>This gap impacts the HSC team’s ability to confirm adoption of guidance, detect implementation issues, and ensure consistent</p>	<p>Management should:</p> <ul style="list-style-type: none"> • Establish a post-implementation review process for compliance advisories to confirm alignment with recommended guidance and identify opportunities for improvement • Incorporate educational elements into advisory responses to enhance understanding and promote consistent application across departments 	<p>Action Plan Owners: Angela Magee Shekeya McCallister Patricia Adkins</p> <p>Action Plan Executive: TBD</p> <p>Due Date: 6/30/2026</p> <p><i>Management will:</i></p> <ul style="list-style-type: none"> • <i>Establish a formal process to review issued advisories after implementation, focusing on cases where monitoring is feasible and the risk level warrants follow-up.</i> • <i>Leverage available tools such as Epic Slicer Dicer, and institutional analytics platforms to confirm compliance with advisory recommendations.</i>

<p>application of recommendations, ultimately reducing opportunities for learning, accountability, and continuous improvement.</p>		<ul style="list-style-type: none"> • <i>Embed educational components into advisory responses to prevent misunderstanding and promote correct application.</i> • <i>Analyze insights from post-implementation reviews to identify recurring issues, inform future advisories, and enhance compliance education.</i> • <i>Document the post-implementation review process and use of monitoring tools in an updated Standard Operating Procedure (SOP) and train compliance staff on the new process.</i>
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Appendix A

Objective, Scope, and Methodology

The objective of the review was to assess the extent to which recipients of compliance advisory opinions have operationalized the guidance in accordance with HSC's intended outcomes, including evaluating whether the process effectively supports recipients in interpreting and applying the advisory guidance they request.

The audit scope covered HSC activities from March 5, 2025, through September 5, 2025, and included a review of a sample of advisory requests and the guidance provided in response.

The engagement procedures included, but were not limited to, the following:

- Interviewing key personnel in health system operations, including clinical and revenue cycle staff
- Reviewing relevant organizational policies and documentation provided by HSC to support advisory responses
- Evaluating recipients' interpretation and implementation of advisory guidance through email responses and interviews
- Reviewing and validating Epic encounters, coding, and billing (where applicable) to determine alignment with the guidance provided by HSC in advisory responses.

We conducted our engagement in conformance with the Institute of Internal Auditors' Global Internal Audit Standards™. To ensure objectivity and independence, the audit team maintained appropriate safeguards throughout the audit process, including clear separation of roles and adherence to professional auditing standards.

This report was prepared by the audit team, with some use of AI-assisted tools to support grammar and wording; all content, conclusions, and judgments reflect the work and review of the auditors.

Executive Sponsor:

Assistant Vice President, Compliance Operations (Vacant)

Key Stakeholders:

Angela Magee, Director, Health Systems Compliance
Shekeya McCallister, Manager, Health Systems Compliance
Brent Townsend, Director, Front End Medical/Surgical Billing
Kelly Kloeckler, Assistant Vice President, Revenue Cycle Operations

Wathen Strong, Director, Front End Medical/Surgical Billing
Patricia Adkins, Compliance Analyst, Health Systems Compliance
Margo Walder, Assistant Director, Front End Medical/Surgical Billing
Claudia Salas, Assistant Director, Front End Medical/Surgical Billing

Audit Team:

Natalie Ramello, Vice President, Chief Compliance and Audit Officer
Philippa Krauss, Assistant Director, Internal Audit
Mia Dinh, Project Manager, Internal Audit
Matt Davis, Kodiak Solutions, Director, Client and Engagement Executive
Kim Cusson, Kodiak Solutions, Director, Engagement Lead
Tasha Chance, Kodiak Solutions, Coding Compliance Auditor

Appendix B

Risk Classifications & Definitions

Each observation has been assigned a risk rating according to the perceived degree of risk that exists based upon the identified deficiency combined with the subsequent priority of action to be undertaken by management. The following chart is intended to provide information with respect to the applicable definitions, color-coded depictions, and terms utilized as part of our risk ranking process:

Degree of Risk & Priority of Action	
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 UT Southwestern 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 UT Southwestern either as a whole or to a significant college / school / unit level. As such, immediate action is required by management 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 UT Southwestern either as a whole or to a college / school / unit level. As such, action is needed by management 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 UT Southwestern 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. 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 on these risks and controls in ways that this report did not and cannot anticipate.