UT Health San Antonio
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Date: July 27, 2020

To: Dr. Robert Hromas, Dean, Long School of Medicine
Dr. Carlos Rosende, Executive Vice Dean Clinical Affairs, Long School of Medicine

From: John Lazarine, Chief Audit Executive
Internal Audit & Consulting

Subject: Audit Report – Practice Plan – Controllable Write-Offs (19-04)

As part of our FY 2020 Audit Plan, we recently completed the Practice Plan – Controllable Write-Offs audit. Attached is the report detailing the results of this review. Management's Action Plans are included the report.

We appreciate the cooperation and assistance we received from the management and staff throughout the review.

Respectfully,

John Lazarine, CIA, CISA, CRISC
Chief Audit Executive
Internal Audit & Consulting Services

Distribution:

cc: Dr. William Henrich, President
Andrea Marks, Senior Executive Vice President and Chief Operating Officer
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UT Health San Antonio
Internal Audit & Consulting Services

Audit Report (19-04)
Practice Plan Collections – Controllable Write-Offs
July 27, 2020

Executive Summary

Objective and Scope

As part of our approved annual Audit Plan, an audit within the UT Health Physicians (UTHP)[1] Clinical Practice Plan was completed. The objective of this audit was to evaluate the effectiveness of payment collection processes and controls over the write-off process within UTHP clinics. The scope of the audit included controllable write-offs processed for medical services performed and administered by UTHP at clinics during Fiscal Year 2019[2] (FY 2019), which totaled approximately $4.5 million (see Appendix A for detailed listing), as well as the collection efforts for patient bad debt accounts, which totaled approximately $5.2 million.

Summary of Results

UTHP has reporting metrics that allow management to appropriately identify and categorize account adjustments/write-offs. The Patient Financial Services group responsible for overseeing UTHP's revenue cycle creates and reviews reports (Department Production Reports) of UTHP's financial earnings and adjustments/write-offs based on varying categories for each department associated with UTHP's Clinical Practice Plan and advises School of Medicine leadership on UTHP's financial position. In addition, the Patient Financial Services group attempts to recoup lost revenue when possible (i.e. refiling corrected insurance claims).

While management captures and reports metrics on account adjustments/write-offs, the audit identified opportunities to improve the associated processes and controls which would significantly reduce the amount of controllable write-offs. In FY 2019, approximately $4.5 million was written off as a result of 33 types of processing errors (controllable adjustments). The top three categories totaled approximately $2.6 million (57%) and were associated with staff (1) not obtaining proper authorizations/referrals, (2) entering incorrect/not covered diagnosis codes, and (3) not obtaining a patient-signed Advance Beneficiary Notice (ABN) form. Based on discussions with UTHP Health-IT, enhancements can be made to Epic[3] that will help to reduce these types of errors.

Additionally, we recommend that management enhance patient collection efforts by contacting patients via email or text message, as well as mailing delinquent notices to the patient's address on file and offering them the opportunity to pay their balance. Currently, staff may contact patients by phone, but only when the patient has additional appointments scheduled. By enhancing the processes and controls, UTHP can increase their net operating revenue by reducing billing errors and increasing collection efforts.

Management has agreed to the results of this audit. The detailed findings, Audit's recommendations and Management's action plans are detailed in the attached table. We would like to thank UTHP leadership and staff for the support and assistance provided during this audit.

[1] *UT Health San Antonio provides clinical services to patients through the UT Health Physicians (UTHP) practice plan. UTHP is comprised of medical specialists and primary care physicians to include faculty from the School of Medicine at UT Health San Antonio. UTHP features more than 700 physicians and health care providers offering advanced services and technologies to patients in San Antonio and South Texas.*

[2] *Fiscal Year 2019 (September 1, 2018 – August 31, 2019)*

[3] *Epic is the electronic medical record system used by UTHP to store patient information and bill patients and insurance payors.*

Distribution
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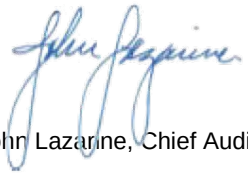
Auditors: Kimberly Weber, Audit Manager, CIA, CFE, CRMA, CICA, CGAP, MPA Brenda Peña, Senior Auditor, CIA, CFE, CICA

Approved for Release	 John Lazarine, Chief Audit Executive, Internal Audit & Consulting Services

	Observation/Condition	Recommendation	Management's Responses
Revenue Leakage – Controllable Write-Offs			
1 **A**	During FY 2019, approximately $4.5 million was written off due to 33 types of processing errors (controllable adjustments). Over $2.6 million, or 57%, of these controllable write-offs were due to staff: (1) not obtaining proper authorizations/referrals, (2) entering incorrect/not covered diagnosis codes, and (3) not obtaining a signed Advance Beneficiary Notice (ABN) form. See Appendix A for detailed list of processing errors. <u>*No Referral/Authorization*</u> Authorizations for procedures were not consistently obtained by clinical staff, resulting in denied claims. Claims are denied if authorizations are not obtained for procedures or if a provider changes the course of treatment without notifying the patient's insurance payor, resulting in the new procedure not being authorized. Currently there is a daily schedule in Epic (Department Appointment Report) that shows front desk staff which patients still need an authorization from the patient's insurance payor. However, staff can easily overlook that a preauthorization was not obtained since the system currently does not stop the check-in process, nor alerts staff via a notification window to obtain the authorization prior to services being performed. For FY 2019, UTHP incurred a financial loss of approximately $1.2 million[4] due to staff not obtaining the proper referral/authorization prior to performing a procedure.	UT Health Physicians should: A1. Implement the Epic interface that allows staff to obtain automated authorizations from large insurance payors. In the absence of automation, create an alert for front desk staff if the authorization field in Epic is blank. In regard to procedures where authorizations were obtained, but the procedure has changed enough to require an updated approval from the insurance payor, management should ensure staff obtain the updated information to make sure claims are paid.	**1.A1** **Responsible Party:** Toby Kennerdell, Senior Director, Patient Financial Services and Casey Peterson Senior Director, Practice Operations **Implementation Date**: February 1, 2021 **Action Plan:** Providers need to confirm pre and post procedure that what was authorized was performed. Review Clinical Operations workflow to review authorized services pre and post procedure with emphasis on Provider Education. **Responsible Party:** Toby Kennerdell, Senior Director, Patient Financial Services and Casey Peterson Senior Director, Practice Operations, Susan Hilgers, Health IT **Implementation Date**: April 30, 2021 **Action Plan:** We will investigate Epic sending a 278R message via our Clearinghouse (TriZetto) and large payors for automated authorizations. If we are not able to send the 278R

[4] *For FY 2019, the $1.2 million in write-offs due to no referral/authorization are made up of two categories of clinical operations:*

- *May's Cancer Center clinical operations 53%*
- *All other UTHP clinical operations 47%*

Losses incurred from the May's Cancer Center operations due to controllable write-offs will be included within the scope of another audit planned for FY 2021 (Mays Cancer Center Infusion Charge Capture & Billing).

	Observation/Condition	Recommendation	Management's Responses
B	*Not Covered Diagnosis* Charges for medical services were denied because of a lack of documented medical necessity and the combination of procedure and diagnosis codes not meeting coverage eligibility, resulting in a financial loss of $711,316. For example, a provider ordered lab exams for a patient and documented "obesity-unspecified" for a written diagnosis. This is not a billable medical diagnosis, since obesity may be viewed as a general medical condition and not a specific medical diagnosis with a corresponding treatment. As a result, the services associated with the diagnosis code[5] of "obesity-unspecified" were not covered, thereby creating a financial loss to UTHP for the services provided. If the physician's written diagnosis had included a medical necessity due to obesity, then staff could have used a more specific billable diagnosis code that would have justified the performed procedures. Furthermore, based on our observations and discussions with UTHP clinical staff and Health-IT, additional training may be needed in order to better coordinate information between the providers and the coders. For instance, if notes within a medical file lead a Coder to determine that a non-specific diagnosis code is needed, instead of using the more general coding, perhaps the Coder could contact the provider to add more information within their notes before the claim is billed and the provider is no longer allowed to clarify their notes.	B1. Require providers to document medical necessity, to include why a procedure was performed. Consider including the words "medical necessity due to…" in the written diagnosis. B2. Utilize a tool to identify unspecified diagnosis codes in order to assist in reducing revenue loss due to claim denials pertaining to not covered diagnoses. C1. Implement the functionality within Epic to generate ABN forms when required. Determine if this functionality can also be used to generate required documents for non-Medicare patients. If not, consider utilizing ABN forms for all types of payors. C2. Enhance the process to ensure patients sign the completed ABN form, or Letter of Agreement, to decrease the risk of a claim being written off.	message through TriZetto, but the payors are able to provide an automated authorization, then we will explore other vendors. For services requiring an authorization, the following steps will need to occur: 1. Identify the key services by department requiring authorization by clinical department and load the CPT codes and Diagnosis codes into Epic to be flagged. 2. Review and implement other changes such as adding a column for the authorization number to the DAR, re-arrange the DAR to make the authorization number field more visible and potentially have the service remain in the Referral WQ if authorization number is missing. **1.B1** **Responsible Party:** Toby Kennerdell, Senior Director, Patient Financial Services and Casey Peterson Senior Director, Practice Operations, Susan Hilgers, Health IT **Implementation Date**: October 31, 2020 **Action Plan:** These write-offs will benefit from the improvements in the ABN enhancements discussed in a later recommendation. Additionally, we will need to review adding specific alerts in Epic for certain scenarios when the payor is not Medicare which result in not medically necessary write-
C	*Advanced Beneficiary Notification* Advance Beneficiary Notices (ABN) are not consistently provided to patients, which resulted in a loss to UTHP of $612,565. Medicare requires that patients sign a completed ABN form to indicate that the patient has been informed that they will be required to pay for any services that Medicare does not cover. If this form is not completed and signed by the patient, and Medicare does not pay for the service, the patient is not obligated to pay and UTHP must write-off the charges.		

[5] *The diagnosis code description corresponds to the International Classification of Diseases (ICD).*

	Observation/Condition	Recommendation	Management's Responses
	Currently, Epic does not indicate when an ABN form is required to be completed and signed by the patient. Instead, when the need for an ABN is identified, staff manually complete a form which requires estimated cost for the procedure, medical codes, and a reason why the procedure could be denied by Medicare. If the ABN form is not properly completed, neither Medicare nor the patient can be held responsible for the payment, resulting in loss of revenue to UTHP. Based on discussions with the UTHP Health-IT group, Epic has the functionality to prefill an ABN form with the required information. However, UTHP does not currently have this functionality installed. Additionally, we noted that non-Medicare patients may also be required to sign a Letter of Agreement, notifying them that some procedures may not be covered by insurance payors, and they will be responsible for the charge. If a Letter of Agreement is not completed and signed, UTHP may incur financial loss. **Risk Rating: Medium**		offs. For example, the Radiology Department will need to review its process to flag either electronically in Epic or manually when certain PET and MRIs are ordered that do not meet Payor guidelines. Additionally, we have installed the Medicare required ACR Select decision support (for appropriate imaging ordering based on problem). We will review ACR Select to see if it can flag potential Medical Necessity denials. **1.B2** **Responsible Party:** Toby Kennerdell, Senior Director, Patient Financial Services and Casey Peterson Senior Director, Practice Operations, Susan Hilgers, Health IT **Implementation Date**: January 31, 2021 **Action Plan:** We will implement a hard stop when an unspecified code is entered to cause the provider to consider another more specific diagnosis code or CPT code. Will review sample unspecified codes with Epic team for potential solutions. **1.C1** **Responsible Party:** Casey Peterson, Senior Director, Practice Operations, Susan Hilgers, Health IT **Implementation Date:** December 31, 2020 **Action Plan:** Implement real time ABN process at time of ordering. Currently

	Observation/Condition	Recommendation	Management's Responses
			part of the EpicCare enhancement plan. The real time ABN process will cause an ABN to be generated at the time of ordering items not covered by Medicare. The Ordering Provider will need to discuss with the patient that the service is not covered by Medicare, that they are still recommending the service, the patient cost for the service (Medicare Allowable) and obtain the patient signature. This will result in a change in each clinical practice's workflow. Provider education will be required. Once the ABN functionality has been implemented, we will review the implementing of non-Medicare ABN. **1.C2** **Responsible Party:** Casey Peterson, Senior Director, Practice Operations **Implementation Date**: December 31, 2020 **Action Plan:** Will have ABN electronically signed. Implementation considered part of 1.C1.

	Observation/Condition	Recommendation	Management's Responses
Past Due Balance Collections			
2	The process to collect past due balances from patients can be improved. Currently, a patient receives three notices in the mail before the full balance is written off[6] and sent to a third-party collection agency[7]. Patients may also be notified by phone of a past due balance when the patient has another appointment scheduled. However, if the patient does not have another appointment scheduled, further attempts to notify the patient by UTHP staff other than by mail are concluded. Efforts to collect prior to the account going to the collection agency could be improved by utilizing additional functionality within the MyChart patient application. MyChart enables patients of UTHP to access their health information online. The MyChart tool can be used to request appointments, view test results and conduct routine communication with providers and the practice. It can also be programmed to send emails to patients with overdue balances and provide them with a link for payment. In addition to the MyChart application, UTHP is currently working towards obtaining a vendor that could also text information to patients, including notices of past due balances. By utilizing additional resources, such as the MyChart application and text messages, the risk of financial loss could be reduced. **Risk Rating: Medium**	UT Health Physicians should enhance collection efforts by contacting patients via email or text notifications prior to sending overdue balances to a collection agency.	**Responsible Party:** Toby Kennerdell, Senior Director, Patient Financial Services **Implementation Date:** March 31, 2021 **Action Plan:** New patient statement vendor RevSpring is anticipated to be operational on October 12, 2020. RevSpring has tools that will help target patients based on the patient's likelihood to pay and then contact the targeted patients via email and text regarding outstanding balances. Will review RevSpring functionality and implement email and text notifications to patients by March 31, 2021. Patient education permission and education likely required.

[6] *Balances are generally written off 90 days from the initial visit.*

[7] *The collection agency and UTHP are paid only on the success of the collection efforts through a split in revenue. The collection agency's fee is 17.4% of the collected amount, and the remaining 82.6% of the collected amount is retained by UTHP.*

Summary of Risk Ratings
Based on the results of this audit, there were no findings considered to be Priority to the Institution. The UT System Internal Audit finding classification system includes Priority, High, Medium, or Low classifications. A Priority Finding is defined as an issue identified by an internal audit that, if not addressed timely, could directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole. Non-Priority Findings are ranked as High, Medium, or Low, with the level of significance based on an assessment of applicable risk factors and probability of a negative outcome occurring if the risk is not adequately mitigated.

APPENDIX A

Controllable Write-Offs
FY 2019
September 1, 2018 – August 31, 2019

#	Controllable Write-Off Category	FY 2019 Total	% of Total
1	No Referral/Authorization Write-Off	$ 1,255,859	27.6%
2	Not Covered Diagnosis Write-Off	711,316	15.6%
3	ABN Write-Off	612,565	13.4%
4	Timely Filing Write-Off- Charge Submission	341,577	7.5%
5	No Documentation Write-Off	336,251	7.4%
6	Timely Filing Write-Off - Registration	263,882	5.8%
7	Timely Filing Write-Off Appeal	143,900	3.2%
8	Coding Write-Off	135,026	3.0%
9	Administrative Write-Off Guarantor	121,221	2.7%
10	Timely Filing Write-Off - Charge Review	104,609	2.3%
11	Enrollment - Write-Off	101,019	2.2%
12	Procedure Benefit Limit Reached - Write-Off	90,973	2.0%
13	Hospice Not Cvd Write-Off	50,193	1.1%
14	Timely Filing Write-Off - Claim Edit	43,709	1.0%
15	Timely Filing W/O Appeal-Coder Response	43,028	0.9%
16	No Authorization Px Authorized Not Performed Write-Off	42,905	0.9%
17	No Response/Rejection Issue	32,870	0.7%
18	POS Not Valid for Procedure	28,204	0.6%
19	UTHSCSA Compliance - Insurance Write-Off	23,994	0.5%
20	Patient Relations Adjustment	23,874	0.5%
21	Timely Filing Write-Off - Guarantor	13,650	0.3%
22	Midlevel Not Payable Per Payor - Write-Off	11,268	0.2%
23	Provider Discretionary Write-Off	7,402	0.2%
24	Insurance Bal After Refund Write-Off	4,575	0.1%
25	Referring Provider Not Enrolled In PECOS/MCD	4,484	0.1%
26	UTHSCSA Compliance - Self Pay Write-Off	3,543	0.1%
27	Timely Filing Write-Off - Charge Review-Research Acct	1,965	0.0%
28	Timely Filing Write-Off - Charge Interface	1,892	0.0%
29	Missing/Invalid Required Insurance Forms	1,666	0.0%
30	Reversal Risk Mgmt - Not Credentialed Write-Off	142	0.0%
31	Risk Management Write-Off	95	0.0%
32	No CLIA Certification Write-Off	(8)	0.0%
33	No Authorization from Secondary Payor Write-Off	(971)	0.0%
	Total	**$ 4,556,679**	100%

Source: Galaxy, which is UTHP's Epic data warehouse