June 6, 2016

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Subject: **Gastroenterology / Endoscopy Services**
Report 2016-16

The final report for Gastroenterology/Endoscopy Services Report 2016-16, is attached. We would like to thank all members of the department for their cooperation and assistance during the review.

Because we were able to reach agreement regarding management action plans in response to the audit recommendations, a formal response to the report is not requested. The findings included in this report will be added to our follow-up system. We will contact you at the appropriate time to evaluate the status of the management action plans.

UC wide policy requires that all draft reports be destroyed after the final report is issued. We also request that draft reports not be photocopied or otherwise redistributed.

David Meier
Director
Audit & Management Advisory Services

Attachment

cc: Margarita Baggett   Laura Handy-Oldham
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UC San Diego

AUDIT & MANAGEMENT ADVISORY SERVICES

Gastroenterology Endoscopy Services
Report No. 2016-16
June 2016

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I. EXECUTIVE SUMMARY

Audit & Management Advisory Services (AMAS) has completed a review of Gastroenterology/ Endoscopy Services as part of the approved audit plan for Fiscal Year (FY) 2015-16. The objective of our review was to determine whether internal controls were adequate to provide reasonable assurance that operations were effective, in compliance with University policy and applicable regulations, and resulted in accurate financial reporting. Based on our initial risk analysis, audit fieldwork was focused on evaluating scope reprocessing compliance and monitoring, professional fee and hospital fee charges review and monitoring, and medical supplies management

We concluded that in general, Gastroenterology/Endoscopy Services business processes and internal controls were adequate, and provided reasonable assurance that operations complied with University business policies and procedures, and applicable regulations. Processes related to scope reprocessing compliance and monitoring appeared to be effective. Gastroenterology/Endoscopy clinical services management works closely with IPCE in reviewing and monitoring of scope reprocessing requirements. However, we identified opportunities to improve processes for more effective charge capture and monitoring of billing for professional and hospital fees, to ensure all completed procedures and services are billed accurately and in a timely manner. Utilizing tools for charge review and reconciliation which were recently implemented and made available to management could assist in these efforts. Management Action Plans to address these findings are summarized below:

A. Professional Services Charge Documentation
GI Services will consider discontinuing the use of paper encounter forms for purposes of professional fee billing, and communicate to providers the need to ensure complete documentation in Epic. Management will coordinate with Medical Group Coding/Health Information Management (HIM) on the transition to ensure questions are addressed and appropriately communicated. Management will continue to review available reports and reconciliation tools for monitoring professional charges, and communicate feedback to HIM and providers to address any issues or concerns. Management will coordinate with Provider Educators and Medical Group Coding/HIM to identify additional training on documentation practices.

B. Professional Services Charge Capture
Management will continue to review scheduled and completed procedures against procedures billed to verify that all professional services charges have been posted. As HIM deploys a reconciliation tool to review linkage between Hospital and Professional charges, routine review of available reports will help Management in ensuring timely, accurate, and complete charge posting. Management will coordinate with Medical Group HIM/Coding and the Provider Educator to identify physician training needs.

C. Technical Fee Charge Capture and Monitoring
Management has hired additional clinic staff and managers at each location, which should help with clinical responsibilities and accommodate administrative functions requiring immediate attention.   Management will coordinate with Revenue Integrity Administration to identify staff

(nurses and technicians) training needs, including timely review and monitoring of WQs and reconciliation tools that identify pending items requiring additional information or documentation from clinic staff.

Observations and related management action plans are described in greater detail in section V. of this report.

II. BACKGROUND

Audit & Management Advisory Services (AMAS) has completed a review of Gastroenterology/ Endoscopy Services as part of the approved audit plan for Fiscal Year (FY) 2015-16. This report summarizes the results of our review.

UC San Diego Health (UCSDH) Gastroenterology and Gastrointestinal (GI) Endoscopy Services provides specialized outpatient procedures, surgery and clinic services that facilitate the diagnosis and treatment of gastrointestinal conditions utilizing leading-edge diagnostic technologies, medical therapies and advanced endoscopy. Recognized for their innovative care of people with GI and liver diseases, Gastroenterologists at UC San Diego work with multidisciplinary teams of specialists, including endoscopists, oncologists, surgeons and radiologists. For 2015-16, *US News and World Report*[1] ranked UCSDH Gastroenterology and GI surgery services in the top 25 in the nation.

Gastroenterology/Endoscopy specialists and staff perform services in several locations at UCSDH Medical Centers in Hillcrest and La Jolla. Gastroenterology/Endoscopy procedures are completed at both locations. GI Motility studies are completed in the West Wing of the Hillcrest Medical Center. Clinic appointments are scheduled in the Hillcrest GI suite and at the Perlman Clinic adjacent to Thornton Hospital in La Jolla. There are currently two procedure units in Hillcrest, three at Thornton and two in Motility. GI services have also been provided in the University Ambulatory Surgical Center (UASC) in La Jolla since December 2009.

During Fiscal Year (FY) 2014-15, Gastroenterology/Endoscopy physicians and staff performed more than 17,256 diagnostic and therapeutic endoscopic procedures. A brief financial overview of the FY 2014-15 Actual figures is provided in the following table.

Table 1

| Fiscal Year 2014-15	Hillcrest	La Jolla
Total Net Operating Revenue[2]	$25,391,149	$53,792,539
Total Operating Expenses[3]	$ 3,150,339	$ 5,362,423
Gain / (Loss)	$22,240,811	$48,430,115
% Salary and Benefits to Total Expenses	71.44%	54.21%
% Medical Supplies to Total Expenses	22.59%	33.13%
Labor Statistics (Procedures Volume)	5,381	11,875
FTE's	19.71	25.07

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[1] U.S. News & World Report http://health.usnews.com/best-hospitals evaluated nearly 5,000 hospitals in 16 adult specialties and ranked the top 50 in most of the specialties, with 3 percent earning national ranking in even one specialty. UC San Diego Health System ranked in 12 specialties, including Gastroenterology & GI Surgery (#24) in the 2015-16 issue of "America's Best Hospitals." Gastroenterology and GI Surgery scored 5 out of 5 in patient safety, 7 out 7 in advanced technologies, and 8 out of 8 in patient services.

[2] Includes Total Inpatient and Outpatient Revenues, and Other Operating Revenue; excludes Professional Fees which are accounted for separately on the Health Sciences side.

[3] Includes Salaries and Benefits of hospital employees, Medical Supplies, Equipment and Utilities, Other Expenses. Salaries and Benefits expenses do not include faculty compensation.

Gastroenterology/Endoscopy Services continues to expand its operations, as evidenced by continued increase in net income from operations since FY 2012, particularly at its La Jolla location.

Figure 1

Gastroenterology & GI Endoscopy Services
Net Income From Operations
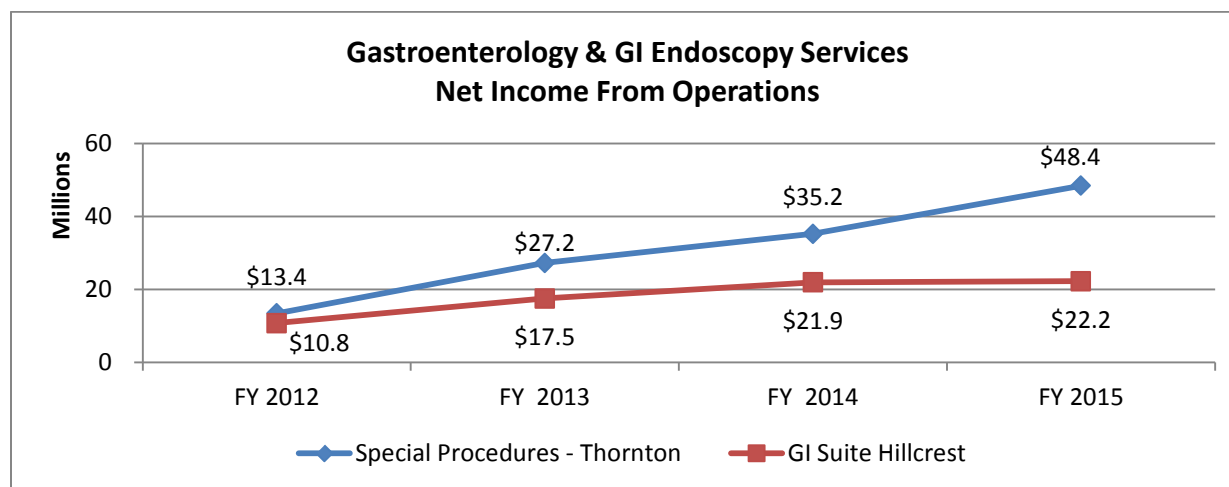
A procedure room in Hillcrest was also being added to accommodate an increase in inpatient procedures. Gastroenterology/Endoscopy expansion at Thornton includes supporting the new Jacobs Medical Center in 2017.

In order to maintain profitability, the FY2015-16 budget projected increasing productivity by 9%, largely in La Jolla. This was projected to yield a total of 7% increase in net income from all of Gastroenterology/Endoscopy cost centers[4] operations. As of December 2015, 43% of this budget has been achieved. At the time of our review, Gastroenterology/Endoscopy Services was in the process of hiring new clinic managers for Hillcrest and La Jolla locations.

The Epic Optime module is utilized in the charge capture process for GI procedures. With the exception of services in UASC, all Gastroenterology/Endoscopy procedures are scheduled by staff in Optime. Charges for clinic visits and procedures are documented in Epic charge entry system each day by GI technicians or nurses at procedure areas or the main OR. Procedure and diagnostic codes or descriptions and medical supplies are entered also by technicians and nurses. Clinic appointments are scheduled and managed in the Epic Cadence module. Physicians post charges for professional fees separately, utilizing Endosoft, which interfaces electronically with Epic, for dictation and documenting images for GI procedures.

Patient charges for clinic visits and procedures are validated and posted by perioperative billers. Hospital charges are linked to the professional charges billing activity initially, however, the Epic system splits the patient charges into professional fees and technical/hospital fees for billing, so charges file

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[4]As of July 2015, Gastroenterology/Endoscopy services created two additional costs centers from its two original cost centers, GI Suite Hillcrest and Thornton Special Procedures. Motility was carved out of the Thornton location, and GI Clinic which was carved out of the Hillcrest location in order to monitor actual productivity and costs unique to its inpatient and outpatient activities.

separately to Epic Resolute for professional billing (PB) and hospital billing (HB). Abstractors for both the HB and PB Revenue Cycle coding units review and process open cases on a daily basis for coding. Cases that require additional work remain in the application work queues until resolved. A charge is created once all documentation and other requirements are complete for a service or procedure completed. Once a charge is billed, the case is closed.

In recent years, bacterial contaminations associated with use of improperly reprocessed endoscopes[5] has been a significant concern at healthcare facilities in the U.S., and has driven changes to the Food and Drug Administration (FDA) approved Automated Endoscope Reprocessors (AER) and chemicals/solutions, and protocols for reprocessing[6] endoscopes. Gastroenterology/Endoscopy services, in coordination with the UCSDH Infection Prevention and Control Environment (IPCE), is responsible for responding to FDA regulatory guidelines, requirements and/or new rules and information issued by the manufacturers of scopes and AER's. Proper reprocessing of scopes is a critical activity requiring complete attention to detail, staff competency and training updates, and compliance with established guidelines.

The Director of Gastroenterology/Endoscopy Services oversees both its clinical services administration for UCSD Health, and the Division of Gastroenterology business administration in the School of Medicine. Clinic staff report to the Associate Director, who manages all activities related to clinical and procedural activities, and supports the Director on administrative responsibilities. At the time of our review, Gastroenterology/Endoscopy Services was in the process of hiring new clinic managers for each clinic and procedure unit in Hillcrest and La Jolla.

III. AUDIT OBJECTIVE, SCOPE, AND PROCEDURES

The objective of our review was to determine whether internal controls were adequate to provide reasonable assurance that operations were effective, in compliance with University policy and applicable regulations, and resulted in accurate financial reporting. Based on our initial risk analysis, audit fieldwork was focused on evaluating scope reprocessing compliance and monitoring, professional fee and hospital fee charges review and monitoring, and medical supplies management. In order to achieve our objective, we performed the following:

- Reviewed applicable Medical Center Policies (MCP) on High Level Disinfecting (HLD), Charge Description Master (CDM) Maintenance, and Charge Entry;
- Interviewed the following:
  - o Director and Associate Director of Gastroenterology/Endoscopy Services
  - o Director of Patient Financial Services
  - o Manager for Hospital Revenue Integrity, CDM and Charge Capture
  - o Assistant Director, Medical Group Revenue Integrity

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[5] Endoscopes are complex reusable devices used in GI endoscopy procedures, that requires complex reprocessing methods including use of FDA-approved AER and disinfectants to prevent and manage or control infection transmission. Regular monitoring, staff education and quality assurance are key in this process.
[6] Reprocessing endoscopes involves several steps after every use including pre-cleaning, cleaning, rinsing, disinfection, rinsing, drying, and storage.

- o   Supervisor and coders, Medical Group Coding team
- o   Provider Educator assigned to Gastroenterology/Endoscopy Services
- o   Storehouse supervisor and storekeeper assigned to Gastroenterology/Endoscopy Services;
- Evaluated management processes for review and monitoring of professional and hospital fee revenues, and related financial reports, as well as medical supplies inventory management and usage;
- Reviewed and evaluated documents and files including the following:
  - o   Financial reports showing 5-year comparison Budget vs. Actual, and FY 2016 YTD July – December 2015
  - o   Scope reprocessing and safety guidelines, procedures and protocols and HLD test logs
  - o   AER vendor/manufacturer guidelines
  - o   Personnel files for staff competencies
  - o   IPCE audit reports and management response and/or corrective actions
  - o   HLD Compliance Monitoring Tool reports;
- Reviewed selected completed GI procedures and services (October 5 -11, 2015) from the schedule report to billing for verification of professional and hospital fees posted charges;
- Reviewed selected billing activity reports (October 5 – 11, 2015) including the days between service date and charge posting date detail to evaluate billing process efficiency;
- Reviewed selected sample of paper encounter forms available for February 2016 for verification of billing activity and posted charges in Epic; and
- Tested a sample of high-value billable medical supplies for verification of billing activity.

The scope of this review focused on general business processes and did not include evaluation of compliance with federal and state regulations that are typically assessed by the California Department of Public Health (CDPH) or The Joint Commission (TJC). In addition, audit tests of charge capture focused on evaluating whether all completed procedures were processed and billed in Epic, but did not include an assessment of whether the correct codes were assigned based on medical record documentation.

IV. CONCLUSION

Based on our review, we concluded that in general, Gastroenterology/Endoscopy Services business processes and internal controls were adequate, and provided reasonable assurance that operations complied with University business policies and procedures, and applicable regulations.

We found processes related to scope reprocessing compliance and monitoring appeared to be effective. Gastroenterology/Endoscopy clinical services management works closely with IPCE in reviewing and monitoring of scope reprocessing requirements. IPCE performs periodic evaluation of compliance with regulatory requirements and MCP relating to scope reprocessing protocols, including High-Level-Disinfection (HLD)[7] processes, safety requirements, proper documentation of test logs, and staff competency.   The Associate Director provides quarterly updates and reports to IPCE on various

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[7] High-Level-Disinfection involves immersion of endoscopes and valves in FDA-approved solutions (which are effective against a wide range of organisms, compatible with the scopes and accessories, environmentally-friendly, and safe for users), at appropriate temperature and contact times.

scope reprocessing and AER solutions test logs, HLD compliance, and AER equipment maintenance. Management takes appropriate action on any issues identified during IPCE unannounced rounds. Management also regularly monitors on-site staff training updates provided by AER and scope manufacturers, and coordinates with Biomedical Equipment Services on maintenance of AERs and scopes. Based on sample test logs, reports and staff competency files reviewed, and the latest IPCE reports[8], we did not identify any recurring issues.

Based on audit tests performed, we identified opportunities to improve processes for effective charge capture and monitoring of billing for professional and hospital fees, to ensure all completed procedures and services are billed accurately and in a timely manner. Utilizing tools for charge review and reconciliation which were recently implemented and made available to management could assist in these efforts.

These issues are discussed in more detail in the remainder of this report.

V. OBSERVATIONS REQUIRING MANAGEMENT ACTION

A.	Professional Services Charge Documentation
Inefficient abstracting processes involving the use of paper encounter forms contributed to increased lag between procedure date of service and charge posting date. In addition, information entered on paper encounter forms did not provide additional value to coding and billing processes.	
Risk Statement/Effect	
Delays in charge posting could result in missed claim filing deadlines and/or lost revenues, and possibly affect revenue and productivity metrics.	
Management Action Plans	
A.1	GI Services will consider discontinuing the use of paper encounter forms for purposes of professional fee billing, and communicate to providers the need to ensure complete documentation in Epic. Management will coordinate with Medical Group Coding/Health Information Management (HIM) on the transition to ensure questions are addressed and appropriately communicated.
A.2	Management will continue to review available reports and reconciliation tools for monitoring professional charges, and communicate feedback to HIM and providers to address any issues or concerns.
A.3	Management will coordinate with Provider Educators and Medical Group Coding/HIM to identify additional training on documentation practices to increase provider confidence in electronic billing processes.

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[8] IPCE provides quarterly updates and reports to the Infection Control Committee, the latest of which was held in March 02, 2016 with Q3 (July – September and Q4 (October – December) 2015 data.

| A. Professional Services Charge Documentation – Detailed Discussion |

Policy (MCP 724.1D – Charge Entry) requires timely and accurate charge processing in order to ensure appropriate reimbursement and to associate accurate cost with the services rendered. The policy also states that: "It is the responsibility of the department manager to ensure timeliness and accuracy; that documentation supports charges, charge entry, error correction, and charge reconciliation procedures are implemented and followed, and ensure that employees are trained in procedures and systems." The policy further states that the department managers are responsible for reviewing available billing and revenue reports to ensure that charges are accurately posted and recorded.

During our review, GI providers continued to utilize paper encounter forms which were forwarded to the Medical Group Coding team, in addition to submitting the charges electronically in Epic. GI had concerns about missing or unbilled procedures/services, in part due to the transition to Epic. In addition, due to organizational changes in Revenue Cycle, GI no longer had a dedicated contact person for questions. The GI Director also indicated that although reports on physician productivity were received via email, the reports were less useful without the availability of a dedicated Medical Group contact to discuss the reports and address any issues. As a result, confidence in the new system and processes remained low, and GI continued to submit paper abstracts.

Because GI providers continued to submit paper encounter forms, coders waited for paper forms to complete the coding of procedures for professional fees. However, the document was not utilized in the abstracting process. Instead, coders utilized the Surgical Case Coding Tool (SCT), which was implemented in September 2015 to allow easier access to documentation and other information required for compliant coding as entered in Epic . Coders were instructed to code directly from the SCT for all completed procedures scheduled in Optime for Gastroenterology/Endoscopy services. A log is created in Optime from the schedule, and appears on the SCT case log report by specialty. Coders access their daily SCT case logs in Optime and review initial procedure/(CPT)[9] and diagnostic codes or descriptions entered by the provider in Epic, related documentation, as well as images and dictation notes processed in Endosoft. Based on the information in the system, the professional fees would be coded. Because coders were required to code based on the system documentation, the paper abstracts did not add value to their process.

In addition, the use of paper encounter forms for abstracting added several additional days in lag due to transport and batching of the paper encounter forms. To evaluate the timeliness of charge entry in the Hillcrest and Thornton GI units, we analyzed days between the procedure Date of Service (DOS) and Charge Posting Date for professional fees. Our sample included one month billing data for October 2015 service dates. A summary of audit results are reflected in the following table.

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[9] Current Procedural Terminology (CPT) Codes are medical nomenclature used to report medical procedures and services under public and private health insurance programs. *Ref. American Medical Association*

Table 2

Number of Transactions reviewed	2,781
Average Number of Days from DOS to Charge Posting Date	21
Number of charges posted more than 21 days after DOS	873 (32%)
Number of Charges posted within 24 hours*	117 (4%)

Charges posted within 24 hours reflected Evaluation and Management CPT Codes

For comparison, the Medical Group indicated that the average lag days in 2014 and 2015 based on a 12-24 month-period was 12 days.

Because inefficient paper abstracting process contributed to delay in coding and charge posting, coders were instructed by Medical Group Coding/Health Information Management (HIM) leadership to no longer review paper forms as of February 2016. In order to evaluate the impact of this change, we reviewed selected paper encounter forms with date range February 18 - 22, 2016, and the associated charges. We found that from this sample, average lag time improved by 5 days, to 16 days from DOS to Charge Posting Date (see Table 3 below) versus the 21 days noted in the October sample. This could be attributable to the fact that coders were no longer waiting for provider paper forms to arrive before coding.

To better understand the difference in coding using paper and SCT, we also examined information written on paper forms, and compared to what was billed in Epic and what was available to coders in the SCT. The following table summarizes our review of selected paper encounter forms with date range February 18 - 22, 2016 and some variances identified when compared with CPT codes billed in Epic:

Table 3

Number of paper forms reviewed	47
Number of paper forms with different CPT code than what was billed in Epic	6 (13%)
Average Lag Days from DOS to Charge Posting Date	16

In addition to the improvement in lag days as previously discussed, we noted that CPT codes and diagnoses indicated on paper were generally found in Epic for the procedures completed and billed. We also found only six of the 47 paper forms reviewed indicated a different CPT code on paper than what was billed. The Coding team indicated that in those cases, the documentation in Epic was not consistent with the CPT on paper, in some cases, procedures could be bundled and billed with one CPT per appropriate coding guidelines. Also, we found that in most cases where differences were noted, the CPT charged in Epic reflected higher value than CPT code found on the paper, which was indicative of higher revenues and relative value units (RVUs) for physicians billed based on coder-selected and billed CPT.

We noted that various tools were available to providers to help management and providers review coding status and corresponding RVUs for surgical cases logged. The following tools should enable management and provider monitoring of procedures billed:

- *Physician Financial Dashboard* – This tool shows the work RVU monthly report that used to be distributed via email to providers monthly. As of September 2015, the report is distributed as an addition to existing Epic component in the "Provider Home" function each mid-month for the previous month's data. The reports shows a rolling 13-months of daily-posted work RVU totals. The Physician Financial Dashboard combines work RVU Report and Optime Charge Reconciliation Report.

- *Optime Charge Reconciliation Report* – This Surgical Case Log Coding Status report was rolled out to GI providers in September 2015. The report shows providers all the cases by service date for the prior month as well as open cases only for the prior period. With each case, the provider-suggested CPT, actual CPT billed, corresponding RVUs, case status & explanation codes are shown. This tool allows management and providers to reconcile the number of procedures completed and billed, and shows differences provider-suggested CPT code versus actual CPT code billed. In addition, the report also displays reasons for the coding status that coders use to communicate to providers to address any missing information or documentation, or other reason for delay, and all missing charges or work RVUs.

GI providers and management have not consistently used the available reporting and reconciliation tools due to issues with access and training which led to inconsistent communication about the tool availability and usability. For example, we noted that in the latest Surgical Log Coding Status reports, the column for provider-CPT code column was empty. This column should populate CPT codes entered by physicians in Epic such as what would be written on the paper encounter forms. These issues are being addressed by HIM and Revenue Integrity.

In addition to the tools described above, UCSDH Clinical Practice Organization has recently hired Provider Educators to coordinate with Revenue Cycle and providers on physician education regarding topics such as code changes, new codes, strategies for improving provider their billing/coding and increasing RVUs with appropriate documentation. Provider Educators plan to conduct quality reviews by specialty, however during our review, the quality review had not been rolled out to the Gastroenterology/Endoscopy services.

B.	Professional Services Charge Capture
Timeliness, completeness and accuracy of charge entry for Professional services could be improved. We noted instances where procedures did not have a corresponding professional charge billed, and some instances where coding for professional and technical charges was inconsistent.	
Risk Statement/Effect	
Missing charges, or inconsistencies in professional and technical billing, could result in lost revenues.	

Management Action Plans	
B.1	Management will continue to review scheduled and completed procedures against procedures billed to verify that all professional services charges have been posted. As HIM deploys a reconciliation tool to review linkage between Hospital and Professional charges, routine review of available reports will help Management in ensuring timely, accurate, and complete charge posting.
B.2	Management will coordinate with Medical Group HIM/Coding and the Provider Educator to identify physician training needs.

B. Professional Services Charge Capture – Detailed Discussion

As indicated above, policy (MCP 724.1D – Charge Entry*)*, requires timely and accurate charge processing, and outlines management responsibility for charge entry, reconciliation, employee training, and review of available reports. In order to evaluate charge capture, we judgmentally selected and reviewed billing activity for 220 completed procedures with service dates October 5-11, 2015 based on Optime Schedule report. We requested both Professional and Hospital billing data and compared the CPT codes charged for Professional services with CPT codes charged for Hospital services. Based on our review we noted instances where procedures where Professional charges were not posted and some inconsistencies in CPT codes billed. A summary of the audit results are included in the following table.

Table 4

Total number of cases reviewed	220
Number of cases not found in PB posted charges	27 (12%)
Total cases with CPT code charged for Professional services that did not correspond with the CPT codes charged for Hospital services	10 (5%)
Total cases not found in Hospital charges	1 (0.5%)

We enlisted Medical Group Coding team's help to further analyze the 10 cases where CPT codes charged for PB that did not correspond to CPT codes charged in HB. A summary of this review is provided in the following table.

Table 5

Number of cases reviewed with mismatched CPT for HB and PB	10
Mismatch due to incorrect code in PB **	4
Mismatch due to incorrect code in HB*	6
Mismatch due to inadequate HB coding*	1
Mismatch due to other reason (MCR account)	1

based on Medical Group coders opinion
***one account had incorrect code both in HB and PB*

We noted that gaps in communication and coordination between the Coding team, providers, and clinic staff may have contributed to variances noted in our sample review as noted in Tables 4 and 5 above.

It also did not appear that consistent processes were in place to review and monitor missing charges or coding discrepancies. While Hospital Revenue Integrity periodically reviews Hospital charges with the Associate Director for Gastroenterology/Endoscopy services, this was not the case on the Medical Group Revenue Integrity side. Management indicated that because of past and ongoing organizational and system changes in the Medical Group business services, communication of new processes, reports and tools had been an ongoing challenge for the past few years. Management had relied on Medical Group Revenue Integrity team in identifying and addressing issues related to charges billed for Professional services, which are accounted for and reviewed separately from the hospital revenue activities . However, periodic monitoring and review of available reports would help management in identifying and escalating issues for resolution as necessary.

At the time of our review, the new leadership for HIM and Revenue Integrity had communicated with the Director for Gastroenterology/Endoscopy Services new reports and reconciliation tools now available to management and providers, as described in Finding A. In addition, HIM is working on a new reconciliation tool called Acustream to review the linkage between hospital and professional charges. This tool should help in identifying and addressing inconsistencies and disconnects in the charge capture process for both PB and HB.

C.	Technical Fee Charge Capture and Monitoring
Timely review and monitoring of Work Queues (WQs) requiring action from the department related to charge entry could be improved to ensure timeliness, completeness and accuracy of technical charges.	
Risk Statement/Effect	
Charges held pending in WQs increases overall lag time between the procedure Date of Service and Charge Posting Date. Delays in charge capture process could result in lost revenues and non-compliance with policy.	
Management Action Plans	
C.1	Management has hired additional clinic staff and managers at each location, which should help with clinical responsibilities and accommodate administrative functions requiring immediate attention.
C.2	Management will coordinate with Revenue Integrity Administration to identify staff (nurses and technicians) training needs, including timely review and monitoring of WQs and reconciliation tools that identify pending items requiring additional information or documentation from clinic staff.

C. Technical Fee Charge Capture and Monitoring – Detailed Discussion

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Policy (MCP 724.1D – Charge Entry*)* requires that charges be posted within 24 hours of the date the services are rendered and resubmitted within 48 hours if rejected on the charge reject report. Charges for technical fees are captured when technicians or nurses at procedural areas enter procedure case logs and required documentation. The Hospital Coding team accesses daily work queues in Epic to match CPT codes, documents, dictation notes, medical records (EMR), and other pertinent information for a clean bill or charge. Hospital coders enter the appropriate codes, or sends a follow-up to physicians or technicians to complete missing information. Charges are posted when service is complete and all required documentations are entered and signed, and appropriate CPT code is entered. Otherwise, it will be routed to an Epic Work Queue (WQ) for additional work. GI staff are responsible for reviewing WQs assigned to them, identifying cases that require additional department review and action, and updating information as needed to complete the charge.   Once a charge is complete and billed, the case is closed, and all charges are billed.

To evaluate timeliness and completeness of hospital charges billed, we reviewed items found as outstanding in WQs 461 and 462, which indicated pending items related to GI procedures. WQ status descriptions indicated "department review needed." The Revenue Cycle Charge Capture Manager indicated that accounts are placed on these WQs when a charge correction needs to be made by GI department. The Associate Director, scheduling manager, and GI technicians have access to these WQs.

We noted that WQs were not updated timely to provide the information needed to ensure that all charge documents are entered into Optime. As of January 26, 2015, we found 28 cases held up in WQ 461 and 462. While this WQ is dynamic and items listed can change on a daily basis, at the time of our review, the WQ listed accounts for patients with discharge dates ranging from July 2015 - January 2016.

If charges held pending in WQs are not addressed, an impact would be seen in overall lag time between the procedure DOS and Charge Posting Date. To identify the timeliness of technical charge entry in the Hillcrest and Thornton GI units, we selected a judgmental sample and analyzed the days between procedure DOS and Posting Date for one month hospital billing data (our sample include 3,285 transactions with October 2015 service dates). We noted that for both locations, 2267, or 69% of charges were posted within 24 hours. Eighty-two percent (82%) of those were outpatient procedures. Motility services require same-day charge, however, only 65% of 186 transactions for Motility services were posted on the same day.   Lag days ranged from 0 - 99 days, with an average of 7 days.

Table 6

Number of Transactions reviewed	3,285
Average Number of Days from DOS to Charge Posting Date	7
Number of Charges posted within 24 hours*	2,267 (69%)
Number of Charges not posted within 24 hours	1,018 (31%)
Number of Charges posted more than 7 days after DOS	792 (24%)

121 transactions were services from Motility which requires same-day charge

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Management indicated that due to clinical priorities, the responsibility for clearing WQs for pending charges is not a top priority for technicians and nurses. In addition, because GI staff responsible for entering charges for GI clinic visits and procedures do not have medical coding experience, they are not able to analyze procedures codes entered in Epic to ensure that appropriate procedure codes have been correctly selected in each case. Management indicated that in many cases, the staff are not exactly sure of the steps needed to correct a charge sitting in the WQs.   In some cases, the same mistakes occur, or a provider is not responsive. Current staffing needs also contribute to the lack of needed time to review WQ's. As a result some of the charges held up in WQs requiring department review contribute to delay in billing timeliness.

Management indicated that options were being considered which may alleviate this issue. One option would be to hire an employee dedicated to performing administrative duties related to billing or coding, instead of relying on technicians who don't have the time and expert knowledge. Another would be to hiring additional technical staff (in progress) which should help in allowing time to review pending charges requiring department review. It appeared that technicians would also benefit from coding education or training to improve knowledge in this area and comfort with the required tasks.