

The logo for UCIrvine, featuring the letters 'UCIRVINE' in a large, black, serif font. The 'U' and 'C' are connected, and the 'I' is a thin vertical line. The 'R' and 'V' are also connected. The 'I' is a thin vertical line. The 'N' and 'E' are connected. The logo is set against a light beige background.

UCIRVINE

The logo for Internal Audit Services, featuring the words 'INTERNAL' and 'AUDIT SERVICES' in a black, serif font, stacked vertically. The logo is set against a light beige background.

INTERNAL
AUDIT SERVICES

Claim Denial Management
Internal Audit Report No. I2019-203
March 26, 2020

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March 26, 2020

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SR. DIRECTOR, REVENUE CYCLE
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**CRYSTAL DEXTER
DIRECTOR, PATIENT FINANCIAL SERVICES
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**RE: Claim Denial Management Audit
Report No. I2019-203**

Internal Audit Services has completed the review of Claim Denial Management and the final report is attached.

We extend our gratitude and appreciation to all personnel with whom we had contact while conducting our review. If you have any questions or require additional assistance, please do not hesitate to contact me.

Mike Bathke

Mike Bathke
Director
Internal Audit Services

Attachment

C: Audit Committee

I. MANAGEMENT SUMMARY

In accordance with the audit plan, Internal Audit Services (IAS) reviewed business operations and other financial activities within Patient Financial Services (PFS) as it relates to claim denial management. The review identified some internal control weaknesses that should be improved to minimize business risks and ensure utilization of best business practices.

While improvement opportunities were noted by IAS, there has been a new system conversion implementation, which has subsequently led to workflow process/procedure changes, reporting enhancements, and other claim denial management improvements. All of these changes have required management and staff in various departments to spend labor-intensive hours re-training, learning and adapting to these new process improvements. The following observations were noted.

Preventable/Avoidable Denials – Ambulatory and Ancillary Care Areas e.g., (consisting of Radiology, Lab, Outpatient/Ambulatory, Oncology Outpatient, etc.) and Patient Access/Registration process significant claims for the Medical Center. However, both areas were responsible for a large portion of claim denials that were preventable or avoidable. Of the total population of denied claims, almost half of them were preventable errors caused by either the Outpatient Clinical or Patient Access/Registration departments. This observation is discussed in section V. 1 below.

Claim Denial Rate – The denial rate of total denials in relation to total claims submitted was 23 percent. This percentage is high in comparison to best practices and the industry average. This observation is discussed in section V. 2 below.

II. BACKGROUND

Denial of a claim is defined as the refusal of an insurance company or carrier to honor a request by an individual, or his or her provider, to pay for health care services obtained from a health care professional. Patient Access/Registration is responsible for obtaining the initial authorization and Utilization Review is responsible for ongoing concurrent authorizations while a patient is in-house.

In November 2017, the Medical Center implemented the Epic enterprise system, which along with new system functionality and several upgrades/updates have caused expected and some unanticipated challenges and setbacks with regards to claim denial management. PFS management contracted with Epic consultants and worked collaboratively with Information Systems' employees to assist with ongoing Epic implementation/customization needs.

The revenue cycle starts with registering a patient, recording insurance (payer) data, providing the appropriate medical care, and then submitting a claim to the payer for services provided. The denial management process is initiated upon payers refusal to pay the claim for a variety of reasons as indicated by claim adjustment codes. These codes are communicated back to the Medical Center. Payers may have different interpretations of the same reason code, and some codes are informational, in that they only advise on the status of the claim. Consequently, the first step in the process is determining the true payment denials versus those that are informational.

Best practice of an effective denial management function entails investigating the reason for the denial, working with the appropriate department (or source of the charge) to obtain additional information in order to satisfy the payer's request/inquiry or further support the claim, and resubmitting the claim to the payer for payment. In the process of investigating a denial and resubmitting a claim, root cause analysis should be performed, and effective steps taken to educate functional areas, as appropriate, to preclude similar denials in the future. This process is spread across a number of different departments. At the Medical Center, denial management responsibilities are shared and coordinated across the following departments.

- PFS has the responsibility for billing, managing, and collecting Medical Center revenue for inpatient and outpatient services. The department facilitates the submission of claims and interfaces with payers. PFS receives notifications from payers regarding the status of the claims received. In addition to the ongoing processing of new claims, PFS coordinates a response to denied claims in order to pursue collection. Failure to provide a timely response may result in the write-off of a portion or the entirety of the applicable claims.
- Patient Access/Registration registers patients, records payer information, and directs patients to the most appropriate inpatient or outpatient setting. The accurate recording of patient, payer and authorization information is vital so

that payers may validate patient coverage status. Authorizations are obtained by either the Central Authorization Unit, the scheduling department, Patient Access, or Clinics.

- Utilization Management Review (UR) is a section within Patient Care Coordination, which oversees the financial piece for inpatients through payer concurrent authorizations. Having access to medical records, case management files and a medical advisor, UR researches and answers specific aspects involving patient care as documented in the medical records. When payers request medical justification for services, UR provides the medical record, and explains the standard of care provided. For inpatients, UR provide patient information to payers to continue to authorize an inpatient stay.
- Case Management is responsible for ensuring patients who are admitted as inpatients, meet inpatient acute criteria. Throughout the stay, Case Management works with the physicians to ensure patients are transitioned to the appropriate level of care, have an active plan of care and are receiving prescribed treatment. They also assist in ensuring there is a plan for the patient post discharge.
- Health Information Management (HIM) coders complete inpatient and some outpatient encounters by assigning the applicable International Classification of Diseases – Tenth Revision, Clinical Modification (ICD-10-CM)¹ or Diagnosis Related Group (DRG)² codes based on clinical documentation within the medical record. Upon completion, the claims route to PFS for submission to payers.

III. PURPOSE, SCOPE AND OBJECTIVES

The purpose of the audit was to perform a general review of claim denial management processes to assess business risk and internal controls. The audit scope included the second half of fiscal year 2018 and the first half of fiscal year 2019. Data prior to the November 2017 Epic conversion were excluded for

¹ICD system was developed by the World Health Organization (WHO) for internationally tracking morbidity and mortality statistics in a comparative way.

²DRGs group related ICD codes based on diagnoses, procedures, ages, sex, discharge status, and presence of comorbidities. Some payers pay based on DRGs.

purposes of this audit, since prior data had been archived and would be a difficult task to retrieve hardcopy data/system archived data.

Additionally, data related to the Federal Qualified Health Centers (FQHC), two facilities located in the Santa Ana and Anaheim areas, was omitted from testing since the fees collected in these facilities are small and include professional fees (the scope of this audit excluded professional fees).

The following audit objectives were included in the review.

1. Denial Management Processes – Reviewed dashboard reports/trend analysis, workflows, system application tools/functionality, root cause analysis, conducted testing and interviews to determine whether claim denials are managed and monitored adequately, accurately and timely.
2. Preventable (Avoidable) Denials – Evaluated denials to determine whether they were preventable, and if so, which areas were largely responsible for those types of denials. Evaluated PFS goals regarding avoidable denials to determine if adequate measures were taken to achieve department objectives.
3. Claim Denial Rate – Conducted testing to determine the claim denial rate and whether the rate was in line with industry standards and best practice.
4. Denial Write-Offs – Tested denied claims to determine how much was written off and assessed the results.
5. Claim Submissions Timeliness– Performed testing of claims to determine the amount of claims not submitted within the proper claim submission time frame. Untimely claim submission denials should be minimal since this process is easy to avoid if proper controls are in place.
6. Epic System Application Functionality – Observe Epic system application functionality since the system was implemented.
7. Staff Training/Meetings – Evaluated training programs and department meetings to determine whether management and staff are provided enough training and are able to keep apprised of new updates with payers and other issues relating to claims/claim denials.

IV. CONCLUSION

Some internal controls related claim denial management could be improved upon. Concerns were noted regarding preventable/avoidable denials and the overall claim denial rate.

Observation details were discussed with management who formulated action plans to address the issues. These details are presented below.

V. OBSERVATIONS AND MANAGEMENT ACTION PLANS

1. Preventable/Avoidable Denials

Observation

IAS reviewed claim denials from May 2018 to April 2019 to determine the number of denials that were preventable/avoidable if claim processing errors/omissions (e.g., registration inaccuracies, insurance ineligibility, invalid codes, medical necessity incorrectness, credentialing omissions, etc.) had been avoided by administrative/clinical staff in various departments. According to a 2014 Advisory Board study, about 90 percent of claims are preventable. Preventable denials should be reduced as much as possible and best practice standards suggest developing a zero tolerance policy for preventable/avoidable denials. Staffing resources and time spent working on preventable denials cause workflow inefficiencies/costs for an organization. Claim reimbursement payments from these preventable denials are considered “low-hanging fruit” and delaying these reimbursements cause increases in accounts receivable days, which may ultimately lead to lost revenue. Our testing revealed that the following two areas could improve their rate of preventable denials.

A. Patient Access/Registration

Of the total population of denials (i.e., avoidable and unavoidable denials) at the Medical Center from May 2018 – April 2019, 21 percent were preventable/avoidable denials that were the responsibility of Patient Access/Registration, amounting to \$155 million in gross charges, not net reimbursable dollars.

In addition, Patient Access/Registration avoidable denials accounted for 35 percent of the total population of avoidable denials.

Of the total Patient Access/Registration denials (i.e., avoidable and unavoidable denials), 96 percent were avoidable. Note that these avoidable denials were predominantly from payers such as Medi-Cal/Medicare, Cal Optima Medicare, BlueShield, IEHP Medicare/Medi-Cal, and Health Net, respectively. The main reasons these claims were denied by these payers were due to lack of eligibility and lack of authorization, respectively.

Along with Ambulatory and Ancillary Care Areas (see section B. below), these Patient Access/Registration numbers are high and indicative of opportunities for the department to strengthen controls over their claim/denial management process.

B. Ambulatory and Ancillary Care Areas

Of the total denial population (i.e., avoidable and unavoidable denials) at the Medical Center from May 2018–April 2019, 24 percent were preventable/avoidable denials that were the responsibility of the Ambulatory and Ancillary Care Areas (e.g., consisting of Radiology, Lab, Outpatient/Ambulatory, Oncology Outpatient, etc.), amounting to \$13 million in gross charges, not net reimbursable dollars. In addition, Ambulatory and Ancillary Care Areas' avoidable denials accounted for 38 percent of the total population of avoidable denials.

Of the total Ambulatory and Ancillary Care Areas' denials (i.e., avoidable and unavoidable denials), 99 percent were avoidable. Note that these avoidable denials were predominantly from payers such as Medicare and Medi-Cal, respectively. The main reason these claims were denied by these payers were due to a lack of documentation (e.g., procedure not deemed a medical necessity, etc.).

These numbers are high and indicative of opportunities for these areas to strengthen controls over their claim/denial management processes.

Management Action Plan

A. Patient Access/Registration

Overall, preventable/avoidable denials have significantly improved from the beginning of the Epic conversion in comparison to more recently. Specifically, PFS Management identified a 60 percent overall reduction of preventable/avoidable denials from the first quarter of 2018 (January 2018 – March 2018) to the second quarter of 2019 (April 2019 – June 2019).

Despite these improvements to the overall rate of preventable/avoidable denials, Patient Access/Registration will continue to perform denial tracking and trending to better understand the types of denials the department is receiving and where the breakdowns are occurring. Furthermore, if necessary, management will perform a Failure Mode and Effects Analysis (FMEA) for each step in the claim process that the department performs and identify any vulnerabilities in the process. Subsequently, management will come up with corrective actions needed and assign responsibility for each of these actions, as applicable. Management will continuously monitor denials that the department is responsible for by using tracking/trending resources and functionality available within Epic and/or other tools.

These action plans mentioned above will be implemented no later than July 15, 2020.

B. Ambulatory and Ancillary Care Areas

For observation details and management action plans, please refer to attached appendix A.

The management action plans in Appendix A., will be implemented by May 15, 2020, unless otherwise stated.

2. Claim Denial Rate

Observation

During our review of denials, IAS noted that from November 2017 to December 2018, the claim denial rate (i.e., total denials in relation total claims)

was 23 percent. According to the American Academy of Family Physicians (AAFP) report, the average claim denial rate across the healthcare industry is between 5 and 10 percent. Furthermore, as best practice, they recommend that providers should aim to keep their claim denial rate around 5 percent to ensure their organization is maximizing claim reimbursement revenue. Note, that the Government Accountability Office (GAO) found that up to one-quarter of claims are denied.

Management Action Plan

Currently, improvements in Epic functionality and customization needs of PFS Management and other areas has allowed better monitoring, tracking, trending of claims and the entire denial management process. In terms of denial management, significant improvement has already been noted from the November 2017 Epic go-live to present with reductions of over 60 percent in preventable/avoidable denials. Denial code mapping, identifying source and root cause has been implemented. In addition, PFS with Information System support are working on benefit plan mapping where a payer will automatically update in Epic based upon eligibility responses. RPA (Robotic Processing Automation) will be implemented during FY 2020, to assist with automating authorization requests and responses.

Since Epic go-live, many system application challenges were presented to PFS and other areas in terms of functionality and customization issues, not to mention training needs in all areas responsible for claim processing and denial management. Due to all of the difficulties involved in implementing a new billing system, PFS management contracted with Epic consultants and worked collaboratively with Information Technology employees to assist with ongoing Epic implementation/customization needs.

APPENDIX A

Claim Denial Management Internal Audit Report No. 12019-203 Ambulatory/Ancillary Response 03/05/2020

Observation: Avoidable/Preventable Denials

Issue	Proposed Solution	Begin Date	Completion Date	Responsible Party(ies)
<p>40-CHGS DONT QUALIFY FOR ER/URGNT CARE. Accounts are being denied with reason code 40, due to registration staff not reviewing RTE responses and identifying that patients are presenting for clinic or ancillary visits with restrictive Medi-Cal, which is only allowed for urgent, emergent or pregnancy related services.</p>	<p>Retrain staff to accurately read RTE responses and if a response returns with a restrictive aid code, then instruct the staff to question the patient regarding full scope Medi-Cal or make the patient a self-pay and collect cash for the visits. Work with PFS to receive a monthly report by location where denials occur</p>	<p>3/16/2020</p>	<p>Ongoing refreshers via Reglines</p>	<p>Ambulatory Managers, Registration QA and PFS</p>
<p>50-NON-CVD, NOT DEEMED MED NECESSITY. Accounts being denied as not deemed a medical necessity with reason code 50, are mainly Medicare accounts. Medicare publishes monthly updates to the LCD's and NCD's and it is imperative that the LCD and NCD file is loaded in a timely manner each month. It is also a necessity at order entry, the ABN is firing for all appropriate procedures, ancillary services and injections and that the physicians are reviewing the ABN prior to finalizing the order.</p>	<p>Work with the Ambulatory Managers, Trainers and Physicians to ensure the physician understands the LCD and NCD requirements for documentation and/or covered diagnosis. Also, work with IT to ensure the LCD/NCD file is loaded by the beginning of each month to ensure the accuracy of the ABN engine. Lastly, work with PFS to receive monthly reports by physician and code that is being denied due to lack of documentation or acceptable diagnosis.</p>	<p>3/2/2020</p>	<p>Timeliness of LCD/NCD File load. Pending IT response; Ongoing for reports and feedback to physicians</p>	<p>Ambulatory Managers, Ambulatory Trainers, PFS and IT</p>

Issue	Proposed Solution	Begin Date	Completion Date	Responsible Party(ies)
56-DENIED, PX NOT 'PROVEN EFFECTIVE.' This is only being denied by Aetna and the procedure is not a covered services	This is not an avoidable denial for Aetna for 91112; will each out to Contracting for assistance. If it cannot be added as a covered service, then work with the clinical team to identify alternatives or set up cash pricing only.	3/15/2020	3/31/2020	PFS; Contracting; Cash Price Team
150-PYMT ADJSTD, LVL OF SVC NOT SUPPTD. Approximately, 99 percent of these denials are Medi-Cal. The denial is mainly is the result of the services in the ED and testing that is performed in the ED is not a covered level of service based upon the final diagnosis. This is not responsibility of Ambulatory	Not Ambulatory responsibility; PFS will meet with ED monthly, to review denials and opportunities for additional recoveries. However, some of the testing is to improve throughput and ED is not willing to change practices that will negatively impact throughput.	3/23/2020	Ongoing	PFS/ED Physicians
151-PMT ADJ, # OF SVCS NOT SUPPTD. This is the result of a number of the same procedure or test within an acceptable defined period of time. There a MUE's that define what frequency of testing is acceptable	Work with IT to configure the MUE edits through the ABN Checker. Also, work with HIM to ensure Epic has the MUE configured during coding	3/23/2020	5/15/2020	IT, PFS, HIM