UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
AUDIT AND ADVISORY SERVICES

Medical Center
Registration – Ambulatory Outpatient Clinics
Project #15-025

March 2015

University of California
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UCSF

Audit and Advisory Services

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David Morgan
Executive Director
Ambulatory Services

SUBJECT: Registration – Ambulatory Outpatient Clinics

As a planned internal audit for Fiscal Year 2015, Audit and Advisory Services ("AAS") conducted a review of registration at ambulatory outpatient clinics. Our services were performed in accordance with the applicable International Standards for the Professional Practice of Internal Auditing as prescribed by the Institute of Internal Auditors (the "IIA Standards").

Our preliminary draft report was provided to department management in January 2015. Management provided us with their final comments and responses to our observations in March 2015. The observations and corrective actions have been discussed and agreed upon with department management and it is management's responsibility to implement the corrective actions stated in the report. In accordance with the University of California audit policy, AAS will periodically follow up to confirm that the agreed upon management corrective actions are completed within the dates specified in the final report.

This report is intended solely for the information and internal use of UCSF management and the Ethics, Compliance and Audit Board, and is not intended to be and should not be used by any other person or entity.

Sincerely,

Irene McGlynn
Director
UCSF Audit and Advisory Service

Registration – Ambulatory Outpatient Clinics
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<u>MANAGEMENT SUMMARY</u>

As a planned audit for Fiscal Year 2015, Audit and Advisory Services conducted a review of registration at ambulatory outpatient clinics. The purpose of this review was to assess the processes and internal controls surrounding the registration process, including opportunities for improvements. Accurate registration processes are important for reducing denials, improving revenue cycle duration, improving patient access, and ensuring that the Medical Center is reimbursed for all services rendered.

Procedures performed as part of the review included interviewing clinic staff, conducting observations of the registration process, and analyzing data on visits for registration completeness and accuracy.

The scope of the review covered transactions and activities for August through November 2014 at clinics for Cardiology, Neurology, and General Surgery.

Based on work performed, policies and procedures are in place for registration practices and clinics are monitoring and addressing registration related issues. Additionally, registration is a focus for process improvement efforts (LEAN), and process enhancements are being implemented on an on-going basis within the ambulatory clinics.

Opportunities for improvement exist in the areas of monitoring for completeness and accuracy of data captured during registration, accurate scheduling, referral processing, coordination of benefits, knowledge sharing of leading practices, and process improvements.

Additional information regarding the observations is detailed in the body of the report.

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TABLE OF CONTENTS

I.   **BACKGROUND**

As a planned audit for Fiscal Year 2015, Audit and Advisory Services (AAS) conducted a review of registration at ambulatory outpatient clinics. The purpose of this review was to assess the processes and internal controls surrounding the registration process, including opportunities for improving processes and standardizing practices.

Ambulatory Services provides about 775,000 visits a year from more than 150 outpatient practices and clinical service departments. The departments selected for this review were Cardiology, Neurology, and General Surgery. As of November 2014, the year to date visits for the respective departments were:

Cardiology: 18,291
Neurology: 15,352
General Surgery: 1,669

Ambulatory outpatient clinics may receive requests for appointments through the Call Center, internal or external referrals, online requests, faxes, or patient calls directly to the clinics. Patients are registered, scheduled, and checked-in using APeX, the Medical Center's electronic health record system. Each clinic is responsible for its own registration and scheduling, though some clinics use the Call Center rather than dedicated employees at the clinics.

For UCSF Medical Center, missing or incorrect insurance information and missing authorizations were in the top reasons for customer complaints and claim denials. Effective registration processes, including complete and accurate capturing of patient and insurance information as well as eligibility and verification of benefits, can help reduce denials, rework, and patient complaints.

II.   **AUDIT PURPOSE AND SCOPE**

The purposes of this review were to evaluate the adequacy of the internal controls over capturing and accurately recording patient information, determine whether the system of internal control is functioning as intended, and identify opportunities for process improvement. Three departments were selected for review based on the potential downstream revenue impact of inaccurate registration or having best practices in place that could be evaluated for adoption across ambulatory outpatient clinics.

The scope of the review covered transactions, workflows, and activities for August through November 2014 at Cardiology, Neurology, and General Surgery clinics.

To conduct our review the following procedures were performed for the areas in scope:

- Reviewed prior UC internal audit reports and the Compliance review for Medicare Secondary Payor compliance;
- Reviewed UCSF Medical Center and Ambulatory and Faculty Practice policies;
- Interviewed key department personnel at all clinics, including registrars and front desk staff;
- Conducted observations and walk-throughs of the processes at selected clinics for each department;

- Assessed process controls at each clinic for registration, scheduling, and check-in;
- Reviewed samples of recent visits for Cardiology and Neurology across clinics to validate that necessary information was being captured appropriately;
- Analyzed all visits from August through November 2014 at Cardiology and Neurology clinics for trends in missing or incorrect information;
- Reviewed reports being used by Cardiology, Neurology, and General Surgery for monitoring registration; and
- Assessed reports currently produced for relevance and potential use by the departments for monitoring registration at ambulatory outpatient clinics.

Work performed was limited to the specific activities and procedures described above. As such, this report is not intended to, nor can it be relied upon to provide an assessment of compliance beyond those areas specifically reviewed. Fieldwork was completed in December 2014.

III.   <u>CONCLUSION</u>

Based on work performed, policies and procedures are in place and available on the Ambulatory and Faculty Practices website for registration best practices and clinics are monitoring and addressing registration related issues. Additionally, continuous improvement is ongoing in this area, with process changes being implemented during the course of this review.[1]

Opportunities for improvement exist in the areas of monitoring for completion and accuracy of data captured during registration, accurate scheduling, referral processing, and coordination of benefits. Additionally, leading practices were identified at the clinics reviewed that may be appropriate for wider implementation. These practices include dedicated authorization staff, creating and distributing physician and visit information, and standardizing the locations within APeX for scanned documents. Existing reports that can be used to enhance the ability of clinics to monitor registration should be considered for general use.

IV.   <u>OBSERVATIONS AND MANAGEMENT CORRECTIVE ACTIONS</u>

1.   **Internal referrals are not always directed to the correct work queue.**

During the observation process at Neurology and General Surgery, it was noted that referrals were not always appearing in the appropriate work queues, leading to delayed patient scheduling. These missed referrals were discovered when patients would call in for the status of a referral. In November 2014, the numbers of referrals without a department name entered into APeX were 14 for Cardiology, 63 for Neurology, including Headache, and 11 for General Surgery. Only one of these referrals was scheduled.

When referrals are entered into APeX, there are multiple options in the "Referred to" category, including Department, Department Specialty, Location, Provider, and Provider Specialty. If the Department is not selected, the referral will not go into the appropriate work queue, and the appointment will not be scheduled. A

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[1] Process improvement initiative (LEAN) of the revenue cycle, including the registration process, is currently in progress.

Referral Lag Report is updated monthly on the Ambulatory and Faculty Practices website that shows the number of referrals without Department selected. This report will be pushed to the practice managers starting in February 2015; however, it does not include the patient details necessary for clinics to retrieve these referrals.

Referrers may not be aware that by only selecting Department Specialty referrals will not enter the appropriate work queue, resulting in non-scheduling of appointments and reduced patient access, which can compromise patient safety.

Management Corrective Action

The Patient Access, Referrals, and Authorizations (PARA) workgroup has proposed that Standard Work Training for referrals be required for new hires, which should help decrease the number of referrals without Department selected. By April 30, 2015, PARA will examine the issue of misdirected referrals and identify the causes and potential solutions including APeX system changes and/or development of a report for clinics to use that provides details on the referrals where no Department has been selected, and therefore not in any of the department's work queue, so that they can be reviewed and processed.

2.   **Complete insurance and demographic information is not always being captured.**

Data analysis of all visits to Neurology and Cardiology clinics from August - November 2014 identified the following:

- Insurance information not linked to the hospital account
- Insurance information missing the subscriber address
- Invalid guarantor dates of birth
- Duplicate visits with the same date, provider, location, and type of visit.

The Call Center does scheduling for several Neurology clinics and as the focus for the Call Center is throughput sufficient attention may not be placed on obtaining full information and thereby contributing to the number of visits with invalid guarantor dates of birth and insurance information that was not linked to the hospital account.

Tested a sample of 20 visits each from Cardiology and Neurology by reviewing the visits in detail in APeX and noted the following:

Issues	Cardiology	Neurology
Insurance cards not scanned	4	N/A
ID Cards not obtained	2	2
Patient demographics not matching the insurance or ID card	1	N/A
Authorizations not obtained when needed	3	1
Acknowledgement of Notice of Privacy Practice (NPP) forms not scanned	9	2

NPPs not documented as given	2	1
Patient addresses not matching between account and visit demographics	3	N/A
Referring provider not entered	N/A	1
Co-pay information not entered	N/A	2

These exceptions may be caused by registrars or front desk staff not fully understanding UCSF procedures and data requirements for patient registration and check-in. Additionally, scanners may not interface well with APeX, leading to delayed or missed scanning of required documents. While there is ad-hoc monitoring of missing registration information by the Clinics such as a selected sample review of arrived patients, a more consistent monitoring process may better identify recurring issues. Revenue Cycle Quality, Education, and Process Improvement has been working on developing reports to monitor for registration quality, such as bypass warnings and scanned NPPs.

If correct and complete information is not obtained and documented during registration or check-in, it may cause billing or compliance issues and the need for additional rework later on in the revenue cycle process.

Management Corrective Actions

1. By May 31, 2015, Ambulatory Services will generate the NPP Report identified by Revenue Cycle Quality, Education, and Process Improvement and provide it to the clinics.

2. By June 30, 2015, Ambulatory Services will generate the Bypass Warning Report identified by Revenue Cycle Quality, Education, and Process Improvement and provide it to the clinics.

3. By August 31, 2015, Revenue Cycle Quality, Education, and Process Improvement, in conjunction with Admitting & Registration and Ambulatory Services, will develop quality standards and identify existing reports that can be used by clinics for measuring registration accuracy.

4. For monitoring items not currently covered by existing reports, Revenue Cycle Quality, Education, and Process Improvement will evaluate the feasibility of creating new reports and a timeline for providing them by September 30, 2015.

5. Effective September 30 , 2015, Ambulatory Services will perform quarterly audits on a sample of registrations to monitor against the quality standards. .

3.   **Staff are not always aware of information required from patients for coordination of benefits.**

During our observation, it was noted that staff did not know that Medicare entitlement date could be used in place of retirement date if the patient could not

recall their retirement date. [2] Also, although staff are aware that patients may not know which insurance was primary or secondary, they did not always ask follow-up questions to determine the appropriate coordination of benefits.

The Medicare Secondary Payer Questionnaire (MSPQ) was recently edited to add a hard stop for retirement date and moved from the scheduling and registration workflow to the check-in workflow. Therefore, front desk staff may not have had sufficient training or practice in gathering the required information from the patients.

When coordination of benefits is not established appropriately, claims are rejected and increased rework is required for payment.

Management Corrective Action

During the course of the review, a tip sheet was created and sent out to the clinics, which should improve the completion and accuracy rates for the MSPQ. This information should be incorporated into the Medicare training module (Checking in a Medicare Patient). By April 30, 2015, Revenue Cycle Quality, Education, and Process Improvement will work with APeX Training and Patient Access to create a plan to improve the APeX Medicare Training. The improved training will be implemented by June 30, 2015.

V.   OPPORTUNITIES FOR IMPROVEMENTS

1.   Processes for obtaining authorizations may not be efficient.

It was noted during interviews and observation that the process for obtaining authorizations and letters of agreement was labor intensive and disrupted the flow of registration and scheduling for registrars. Additionally, up-to-date requirements were not always known or easily accessible by registrars in the course of their workflows.

Neurology has a dedicated authorizations group that focuses on obtaining authorizations or letters of agreement as needed. As they are processing multiple patients at a time with each insurance company, and have specialized coding and contract knowledge, they are able to obtain authorizations more efficiently. When the authorization group was established in Neurology, management noted a significant decrease in denials due to lack of authorization.

Additional improvements could be made to the process for obtaining authorizations, as California Children Services (CCS) authorizations are not being obtained by the Neurology authorization group, which can delay scheduling of affected patients. Furthermore, although monthly reports of open encounters are sent to physicians, untimely closing of prior visits has caused denied authorizations on subsequent visits.

Efficient and effective authorization processing can reduce rework needed; lack of authorizations was a large category in both RFI work queues and denials.

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[2] Retirement Date is a key field required for the Medicare Secondary Payor Questionnaire.

Management Corrective Action

By June 1, 2015, Ambulatory Services will evaluate the creation of dedicated authorization units for departments based on the volume of visits and specialties.

2. **Patients may be scheduled for incorrect appointment types causing ineffective use of available appointment times and the need for rescheduling.**

For Cardiology, it was noted that follow-up patients were scheduled in new patient spots. As a new patient appointment is 45 minutes long and a follow-up patient appointment is 30 minutes long, this mismatch in scheduling caused a 15-minute appointment to show on the schedule. In one case observed, a scheduler had made an appointment for a follow-up patient in the 15-minute opening, leading to an overbooking for that day and required rescheduling of the appointment.

The APeX scheduling module, Cadence, allows override of appointment type; therefore, non-dedicated patient schedulers may not be aware of the issues created by scheduling follow-up patients in new patient spots.

When patient type is not matched to appointment type, there may be the need to reschedule patients, which inefficiently uses resources and causes patient dissatisfaction.

Management Corrective Action

By July 1, 2015, Ambulatory Services will train schedulers on the need for matching patient type to appointment type.

3. **Referrals may not be made to appropriate physicians and required tests may not be obtained prior to the referral.**

Not all registrars could always identify which physicians the patients should be seeing, and re-work had to be done on mismatched appointments. Additionally, different visits may have different pre-requisites (tests or labs performed, providers seen, etc.); therefore, it is important to schedule appointment with the correct specialty physician.

General Surgery has developed easily accessible matrices that help schedulers ensure that appointments are scheduled with appropriate physicians and that required tests have been performed prior to scheduling the patient visit.

When patients are not matched to appropriate providers or do not have the required tests done prior to the visit, there may be the need to reschedule patients, which inefficiently uses resources and causes patient dissatisfaction.

>> **Management Corrective Action**
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>> By July 1, 2015, Ambulatory Services will identify clinics for which physician specialty and visit pre-requisite matrices would be useful and develop a template these units can use for creating these matrices.

4.   **Documents are not being scanned into consistent places in APeX.**

>> In reviewing the sample of visits for Cardiology and Neurology in APeX for completion of required documentation, it was noted that documents are not being consistently scanned into the same location within APeX at each of the clinics. Some Terms and Conditions and NPP Acknowledgment forms were placed in Admin documents rather than the document checklist, or scanned as one item with a combined title.
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>> While there is a matrix of documents required to be scanned into APeX, along with a tip sheet of procedures on the Ambulatory and Faculty Practices website, the front desk staff did not have it easily accessible for reference. Additionally, the matrix and tip sheet were a recently added resource, and staff may not be familiar with it yet.
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>> When documents are not scanned to consistent locations, monitoring compliance on the issuance and completion of required documents may not be effective.
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>> During the course of the review and as part of the Enterprise Content Management program, a list of required documents to be scanned and the locations was posted on Ambulatory and Faculty Practice website and included in the monthly website update e-mail.

5.   **Reports to effectively monitor clinic registration and scheduling activities are not available and/or used.**

>> During interviews, it was stated that, while some reports are sent regularly to the clinics to help with monitoring, they do not cover all the areas the clinics would like to measure, such as missing insurance or demographic information, or errors by the user. Clinics are therefore doing ad hoc monitoring or creating their own reports, which is a labor-intensive process that reduces resource availability for other purposes. A standard set of reports available for all clinics would enhance the efficiency and effectiveness of the monitoring process.
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>> Existing reports available to Clinics that may be helpful to be run regularly are:
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>> - Appointment Scheduling Lag time
>> - Referral Processing Time Report
>> - Duplicate Patients by User
>> - Registration Verification rate and Lead Time Report
>> - Registration Related
>> - Registration Timing Report

Management Corrective Action

By May 1, 2015, Ambulatory Services will perform an assessment of existing reports available in APeX to determine whether they meet the clinics' needs. Any additional reports identified should be requested from the APeX reporting team to create a set of standard monitoring reports for outpatient clinics.

6. **The decentralized registration and access management within the outpatient Ambulatory Clinics makes it difficult to institute consistent practices and quality standards across all Ambulatory Clinics.**

Although, a common electronic health record system is used for registering patients, the decentralized responsibility for access management may be a contributory factor to the inconsistent practices observed in the three areas reviewed.

Management Corrective Actions

1. By August 1, 2015, Director of Patient Access in conjunction with Revenue Cycle Quality, Education, and Process Improvement and Assistant Directors of Ambulatory Services will develop a comprehensive set of quality standards against which all clinics can be measured.

2. By October 1, 2015, Ambulatory Services will begin monitoring against those standards and provide feedback to clinics.