

UCLA AUDIT & ADVISORY SERVICES



Edwin D. Pierce, CPA, CFE
Director

Craig Whiteburch, CPA, CIA, CFE
Associate Director

10920 Wilshire Boulevard, Suite 700
Los Angeles, California 90024-1366
310 • 794-6110
Fax: 310 • 794-8536

September 13, 2018

**SENIOR VICE PRESIDENT/CHIEF COMPLIANCE & AUDIT OFFICER ALEX BUSTAMANTE
EXECUTIVE VICE CHANCELLOR & PROVOST SCOTT WAUGH:**

Re: Patient Business Services – Denials Audit Report #18-1211

The audit of Patient Business Services (PBS) – Denials has been completed, and the results are detailed below, with management's responses incorporated. This audit was conducted as part of the Health Sciences audit plan for 2017-18.

Background

PBS has established a solid infrastructure to evaluate and monitor denials. There are 50 budgeted collection representatives. Four collection managers, two billing managers, and the assistant Billing Management Director work with the PBS director to identify root causes and trends for denials. However, their focus has been on high dollar inpatient accounts. Resources have not been available to assess root causes or trends for lower dollar, outpatient account denials, which have a high volume and can be time consuming to process.

In April 2018, the Hospital received 8,611 denials totaling \$25,883,422.

Purpose and Scope

The purpose of the audit was to identify root causes or trends relating to Laboratory denials for selected reasons. The Laboratory was chosen for this review because it consistently generates a high volume of denials. Also, the Laboratory has inherent challenges in managing denials because it is reliant on physicians and clinics to properly place orders and verify patients' insurance.

The scope of the engagement covered Laboratory denials that were received between January and March 2018 due to the payer's determination of a lack of medical necessity (reason 50). There were 987 such denials during this timeframe, totaling \$148,917.

Audit work included a review of the standard PBS denial report, which includes data fields for patient account number, date of service, denial amount, and payer. The auditor sorted the denial data by dollar to attempt to identify certain tests that were repeatedly denied. The auditor selected 120 denials (which included 206 tests) for detailed review. For each denial, the auditor reviewed the patient's account/chart in CareConnect and determined which test(s) were denied, the physician who ordered the test(s), and the ordering department. The auditor also verified the nature of the denial by reviewing the account notes.

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Audit Results

The audit indicated that, generally, denied laboratory tests due to lack of medical necessity are initiated from several different providers within several different departments. However, some trends were noted, as detailed below.

Denied Tests by Payer

- The primary payer was Medicare for 204 of the 206 denied tests reviewed.

Denied Tests

- The most frequently denied tests were Vitamin D, 25-Hydroxy (Current Procedural Terminology [CPT] 82306/\$190) and Hemoglobin A1C (CPT 83036/\$60). The audit sample of 206 tests included 48 denied Vitamin D, 25-Hydroxy tests and 46 denied Hemoglobin A1C tests.

Denied Tests by Ordering Department

- A significant number of denied tests, 48 of the 206 reviewed, were ordered by non-UCLA providers.
- The UCLA department with the highest number of denied tests was Westwood Neurology, with 42 denied tests. The 100 Medical Plaza Internal Medicine Suite #490 had 17 denied tests.
- The following departments had between seven and nine denied tests:
 - Clark Urology Center
 - Gonda Diabetes Center
 - Internal Medicine Suite (Morton [200] Medical Plaza)
 - Hematology Oncology 100 Medical Plaza Suite #550
 - Medical Specialty Suites
 - UCLA Cardiovascular Center

Denied Tests by Authorizing Provider

- One non-UCLA provider had 36 denied tests. Another non-UCLA provider had 7 denied tests.
- Two providers from Westwood Neurology had 23 and 8 denied tests, respectively.
- A provider from 100 Medical Plaza Internal Medicine Suite #490 had 14 denied tests.
- Five providers from various departments had between four and six denied tests.
- Six providers from various departments had three denied tests.

Venipunctures

- Of the 987 denials attributed to lack of medical necessity between January through March 2018, 260 were for \$10 procedures, most likely venipunctures, which are not covered by commercial payors. These are not true denials for lack of medical necessity. (These were not included in the sample, but the auditor haphazardly scanned several accounts and determined these to be venipunctures.)

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Audit results are further detailed in the following exhibits:

Exhibit A – Denied Tests by CPT Code

Exhibit B – Denied Tests by Ordering Department

Exhibit C – Denied Tests by Authorizing Provider

Exhibit D – Denied Tests by Amount/Distribution of Sample

*Patient Account details of cases reviewed will be provided to PBS separately.

Audit Recommendations

- 1) A work group is currently making efforts to implement an advance beneficiary notice of non-coverage (ABN) process using CareConnect functionality. A&AS supports this effort, as having an ABN process will allow PBS to bill patients who sign such an acknowledgement for tests denied by Medicare. The work group should determine the best process for handling non-UCLA providers.

Management Response: PBS and Laboratory Administration concur with the A&S recommendation to continue to pursue convincing our UCLA Medical Staff of the benefits of implementing the CareConnect ABN functionality. The work group will strive to identify and implement best practices for handling non-UCLA providers.

- 2) PBS should work with the Office of Health Information and Analytics (OHIA) to develop a more comprehensive report for laboratory denials attributed to lack of medical necessity (reason 50). The report should include the denial amount, CPT codes denied, authorizing provider and ordering department. Ideally, the laboratory order attached to the denied test should be used to determine the authorizing provider and ordering department. (The Laboratory shows as the ordering department for paper requisition orders not placed through CareConnect.) If that is not possible, the authorizing provider is also displayed on the lab encounter (referred to as billing provider) and the remittance image (referred to as rendering provider).

Such a report could be used to easily identify recurrent denied tests, as well as providers or departments that consistently have the same tests denied for lack of medical necessity. Initial efforts to implement an ABN process can focus on these providers and departments. Also, additional education can be provided to physicians by the Office of Compliance Services to ensure that physicians are not inadvertently omitting appropriate diagnoses for these tests.

Management Response: PBS concurs with the A&S recommendation to modify our current denial reporting to capture more meaningful components to aide analytics in trending, tracking and managing laboratory denials. The revised report has been requested and is being prioritized by OHIA.

- 3) To avoid skewed denial data, PBS should determine whether venipuncture charges can be handled differently. Perhaps, for those patients with commercial payors, venipunctures should not be billed.

Management Response: PBS concurs with the A&S recommendation to seek better handling of laboratory venipuncture denials for payers who routinely do not cover this charge. We shall inquire with our CareConnect HB [hospital billing] partners regarding prorating these as non-

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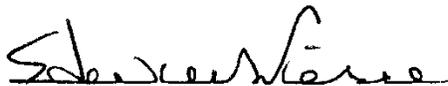
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covered charges at the time of billing or adjusting them systematically at the time of posting, to avoid known denials.

The corrective actions implemented or planned by management satisfactorily address the audit concerns and recommendations. In accordance with our follow-up policy, we will conduct a review to assess the implementation of all corrective actions approximately four months from the date of this letter.

If you have any questions, please do not hesitate to contact me.



Edwin D. Pierce, CPA, CFE
Director

cc: R. Azar
R.A. Davis
B. Lodge-Lemon
J. Spisso, M.P.A.
P. Staton
L. Yost

Enclosures

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