June 22, 2023

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Subject: ***Authorizations***
Report 2023-14A

The final report for Authorizations Report 2023-14A, 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.

Christa Perkins Digitally signed by Christa Perkins
Date: 2023.06.22 07:15:45 -07'00'

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UC San Diego

AUDIT & MANAGEMENT ADVISORY SERVICES

Authorizations
Report No. 2023-14A
June 2023

FINAL REPORT

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I. EXECUTIVE SUMMARY

Audit & Management Advisory Services (AMAS) has completed a review of Authorizations at UC San Diego Health (UCSDH) as part of the approved audit plan for Fiscal Year 2022-23. The objective of our review was to evaluate whether internal controls for authorizations for UCSDH services and procedures provide reasonable assurance that operations are effective, activities are compliant with relevant policies and procedures, and to identify the overall impact on UCSDH financial results.

Based on our review, we concluded that internal controls for authorizations for UCSDH services and procedures provide reasonable assurance that operations are effective, activities are compliant with relevant policies and procedures. Patient Access Financial Clearance Center (FCC) management has made significant improvements to business processes in the past three years since January 2020 under new leadership, including the development and documentation of standardized processes, procedures and guidelines for authorizations, and consolidation of WQs for efficiency and accountability. In addition, there is an organization-wide referral optimization project currently in progress to evaluate issues including ensuring departments are placing follow-up orders for return visits so there is sufficient time to secure an authorization.

FCC has implemented the use of a clinical override report and discussions with management in order to reduce the abuse of the clinical override cases. As a result, the number of patients being seen without an authorization on file has been reduced with improved usage of the override for medically necessary situations only. Management has indicated that with the authorization work that Revenue Cycle has completed, including the clinical override case improvements, FY 2021-2022 controllable losses were reduced by 15.4%, or $18.5 million, compared to FY 2020-2021.

During our review we noted opportunities for improvement with efficiency in securing authorizations, Work Queue (WQ) management, reporting for denials and authorization key performance indicators (KPI), and quality control and performance monitoring processes in decentralized authorization departments. Management Action Plans to address our findings are noted below:

A. Efficiency in Securing Authorizations

1. FCC management is partnering with UCSDH Revenue Cycle Analytics & Continuous Improvement to review the authorization not required trends by payor or specialty and update the Auto Status Assignment (ASA) to reduce waste in WQs by redirecting referrals that do not require an authorization.
2. FCC management is finalizing the project with UCSDH Revenue Cycle Analytics & Continuous Improvement evaluating CPT mismatches between the actual authorization certification record and what was billed on the claim, with the goal to identify these in a WQ prior to claim submission.
3. FCC management has filled the advanced billing position that will be trained to assist the FCC team with authorizations for multiple specialties, researching denials, educating staff, reviewing WQs and reports.
4. FCC management will continue to provide authorization process training to new and current team members and float team members on insurance changes, standardized processes, outgoing referrals and any other areas of high risk or concern. Management should consider re-visiting the authorization boot camp.
5. FCC management will verify there are documented standard processes for critical pieces of the authorization workflow and staff are aware of these processes. This will include the

review and streamlining of the Epic Insurance list if possible. Management will provide additional education or documentation of tips for staff to select particular payors when one payor has multiple options.

6. FCC management will reinforce guidelines for how long they delay a record according to the payor before they check it to see if anything is needed.
7. FCC management will review communication methods to reinforce to staff the different forms of communication related to authorizations using Epic In Basket, Outlook, Secure Chat or Microsoft Teams. These communication methods will be documented in formalized procedures and training including their expected usage based on the department, specialty and/or location.
8. The Payer Authorization Steering Committee will identify centralized and/or decentralized departments that require referral optimization, have documentation gaps, or have outdated standardized processes for improvement. As part of this process, FCC management and Revenue Cycle leadership will continue to provide guidance and best practices for all departments to implement.

B. WQ Management

FCC management will continue updating and replacing central authorization WQs for the inpatient CAT and cleaning up old central authorization accounts that have been in a WQ over 90 days.

C. Reporting for Denials and Authorization Key Performance Indicators (KPIs)

1. FCC management has worked with UCSDH Revenue Cycle Analytics & Continuous Improvement to establish effective denial reporting on a consistent basis and a process for management to share those reports with the teams.
2. FCC management will continue to work with UCSDH Revenue Cycle Analytics & Continuous Improvement to establish lag-based reporting of authorization key performance indicators for all WQs in order to provide management with an effective reporting system to trend issues and manage the authorization process in addition to monitoring quality review.
3. The Payor Authorization Steering Committee and FCC management will assist in reinforcing training and reports available for decentralized authorization departments to utilize and manage denial and lag-based reporting for quality assurance and authorization management.

D. Quality Control and Performance Monitoring

FCC management will provide guidance on how to implement process for quality and performance monitoring in decentralized departments. This will be a part of the goals of the new Payer Authorization Steering Committee including full representation from all involved centralized and decentralized department currently being implemented by Patient Access.

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 Authorizations at UC San Diego Health as part of the approved audit plan for Fiscal Year 2022-23. This report summarizes the results of our review.

Authorization, also known as precertification, is a process of reviewing certain medical, surgical, or behavioral health services to ensure medical necessity and appropriateness of care prior to services being rendered, and to determine whether the service being requested is a covered benefit under the patient's benefit plan. Authorization is one of the key components of the Financial Clearance process (Financial Clearance) outlined in the UCSDH Patient Financial Policy (UCSD Health Policy (UCSDHP) 750.1). Authorizations are only required for certain services, and may be obtained prior to service, during an admission, or retroactively for services rendered.

Most authorizations functions at UCSDH have been centralized within the Patient Access Financial Clearance Center (FCC). This unit verifies insurance coverage and secures preauthorization for surgery, radiology, and imaging services across 174 specialties and locations within UCSDH. There remain seven specialties and/or locations[1] which retain oversight for their own authorizations in a decentralized / hybrid model. The Patient Financial Policy indicates "While the authorization function is not always centralized, it is the expectation that securing of the authorization is standardized across UC San Diego Health."

The Patient Financial Policy documents four major types of Financial Clearance :

1. Patient is covered by third-party source.
2. Able and willing to pay estimated UCSDH charges per Letter of Agreement (LOA).
3. Approved for "Charity" (financial & clinical justification).
4. Clinical Override (for non-EMTALA[2] bound patients).

The Patient Financial Policy further states "The ability to complete the financial clearance process (which may result in the patient being financially cleared or not prior to service) depends in part on the physician (or designee) and the patient working with the Financial Clearance staff to provide necessary information timely. This process may change over the course of a patient's care and may need to be repeated throughout a course of therapy."

The appropriate designated UCSDH staff, including hospital assistants, medical assistants, and authorization specialists, will attempt to secure authorization, either pre-service, during an admission, or retroactive to the services being rendered. This information is documented in the referral shell of Epic[3]. This record is used by a variety of other end-users, including providers and billers.

Several process improvement efforts in addition to the centralization of additional department authorizations processes have been initiated in recent years. The FCC has established and documented Authorization Referral Guidelines, a universal set of guidelines which aligns with industry-

[1] There are two identified specific decentralized specialties / locations (Women's Health (for certain services) and Cardiology (except for VTC Cardiology)) which also have centralized specialties / locations.
[2] EMTALA is the Emergency Medical Treatment and Labor Act, which was enacted to ensure public access to emergency services regardless of ability to pay.
[3] Epic is the Electronic Health Record (EHR) system used by UCSDH.

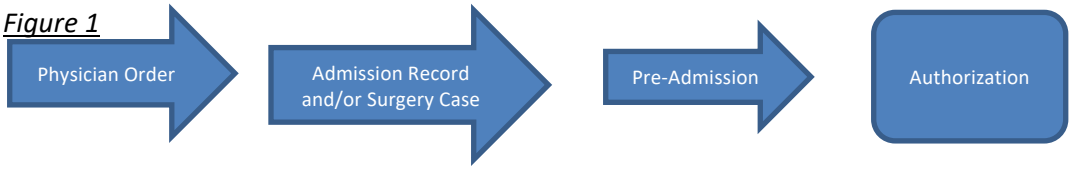
wide standards to ensure process efficiency and the highest level of patient satisfaction. These guidelines include standards for number of days a referral or authorization / certification should remain active or pending in an Epic work queue (WQ). Authorizing and attaching a referral to a patient's scheduled visit decreases the risk of a denied claim. In addition, a payor scheduling authorization matrix is included in the guidelines to reduce rework and assure authorization is secured pre-service. Per the Authorization Referral Guidelines, the standards for the number of days a referral or authorization/certification should remain active or pending is detailed as follows:

Priority	Initial Authorization Submission	Follow Up Authorization Status
STAT	Within 1 business day	1x daily until resolved
Urgent	Within 2 business days	1x every other day until resolved
Routine	Within 3 business days (if appointment date is in the next 30 days)	1x every 3 days until resolved
Services which do not schedule until authorization is secured	Submit per department protocol	Follow up 1x every 3 days until resolved.

The accurate recording of patient, payor and authorization information is key so that payors may validate coverage status. An authorization for services is typically generated from a physician's order. There are three main methods of authorization which are detailed below:

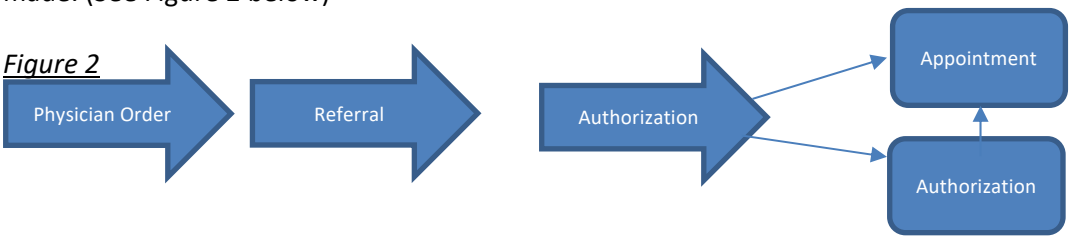
1. *Authorization for Pre-Admission and Surgical Procedures:* Initiated with the physician's order which automatically creates a surgery case and/or admission patient record. The authorization/certification is then created for processing and documenting authorization. The authorization result is documented in a pre-certification status. If it is authorized, the pre-certification status should indicate this and document the authorization number. Surgical procedures could be inpatient or outpatient. (See Figure 1 below)

Figure 1



2. *Authorization for Outpatient Visits and Consult Services (Referrals)*: Requires a physician order, which generates a referral and, once authorization is secured, the appointment scheduling can begin. There are instances where an authorization will be secured after an appointment is made. (See Figure 2 below)

Figure 2



3. *Authorization for Inpatient Process:* Starts with the Emergency Department notification of the admission process, then the initial notifications of admission are sent by Admission staff after registering, verifying coverage, and admitting the patient. Notification is sent through Epic once the patient is registered and verified based on payor logic and WQ rules when a patient is "admitted." The inpatient Centralized Authorization Team (CAT)[4] takes over the process and verifies the coverage before the CAT contacts the payor and secure authorization. *(See Figure 3 below)*

Figure 3

Referrals can be accessed through the WQ lists that can be assigned specifically to individual authorization coordinators. WQs continuously evaluate referral records and pull in qualifying referrals.

There are two main WQ types that house referral records that require authorization used by FCC, which are:

- *Referral WQs*: Designed for working on scheduled orders or unscheduled orders[5] requiring review and update or on the status of authorization.
- *Patient WQs*: Designed for working on identifying missing authorizations based on a scheduled visit or preadmission.

WQs are used for tracking, acquiring, and accessing records to create or complete related functions. The WQ is where the authorization information for the referral and/or note to the referral can be edited. If the patient coverage is incorrect, authorization requirements and payor authorizations will also be incorrect. Any changes to this information will direct the referral back to the WQ as a new referral and the whole process will start over.

Patient Access currently manages 37 WQs with four managers and six supervisors. FCC partnered with UCSDH Continuous Improvement training team, a part of Revenue Cycle Operations, to review all Epic learnings and new hire trainings to ensure trainings were complete and accurate. FCC also partnered with Revenue Cycle Management Analytics & Continuous Improvement to evaluate WQ management and this process resulted in an 80% reduction in authorization WQs last year.

Decentralized departments primarily process authorizations through WQs assigned to their specialties / locations; however, there are departments that have not fully implemented the WQ authorization process.

The authorization process is connected to other functions, such as scheduling, so each component affects the overall workflow. User knowledge and an understanding of the relationship between each record linked, and the importance of the information entered in the data fields, are key to ensuring

[4] The FCC Inpatient Authorization Team is referred to as "CAT", the Central Authorization Team.
[5] Providers submit an order for a patient's procedure which may be scheduled at that same time or may remain unscheduled until the clinic follows up with the patient.

records flow to the intended recipient for the next part of or completing the process. Training and communication are ongoing necessities.

The FCC has control over certain functions to minimize denials including a portion of coordination of benefits, authorization, and registration/eligibility, although coordination is needed by many other functions to accurately and efficiently process authorizations and minimize denials. The Analytics & Continuous Improvement team provided denials and net collection rate (NCR) data as illustrated in Tables 1 and 2 below. Management considers NCR a key metric to measure how effectively a division is at collecting all legitimate forms of revenue. This data also compares the NCR for hospital billing and professional billing to UCSDH overall.

III. AUDIT OBJECTIVE, SCOPE, AND PROCEDURES

The objective of our review was to evaluate whether internal controls for authorizations for UCSDH services and procedures provide reasonable assurance that operations are effective, activities are compliant with relevant policies and procedures, and to identify the overall impact on UCSDH financial results. In order to achieve our objective, we performed the following:

- Reviewed the following:
  - Authorization Referral Guidelines, department specific standard processes for authorizations and Epic Tip Sheets;
  - Patient Financial Policy (UCSDHP) 750.1;
  - Training materials provided to individuals with authorization responsibilities for Authorization for Inpatient and Surgical Procedures, as well as Referral Authorization for Outpatient and Consults;
  - Productivity measures and monitoring plan and actions;
  - Quality control process;
  - Data analytics / reports provided by Revenue Cycle Analytics & Continuous Improvement, including WQ 2701 Lag Indications, Cancellation + Rescheduled Summary and Hospital Billing, and Professional Billing WQ 2701 Reimbursement and Denial Data;
- Interviewed the following:
  - Chief Revenue Cycle Officer and FCC Patient Access Director for FCC Administration;
  - Patient Access Service Supervisor;
  - Patient Billers;
  - CAT for the inpatient authorization process;
  - Revenue Cycle Analytics & Continuous Improvement team involved with gathering data for cancelled and rescheduled encounters, denial reports, WQ design and Lag Indications Report;
- Performed the following:
  - Process walkthrough for authorization functions performed by assigned coordinators or individuals in selected centralized and decentralized authorization units;
  - Process walkthrough for the CAT inpatient authorization process;
- Evaluated the following:
  - Clinical Override process and tested a sample of five procedures approved through this process during December 2022 for compliance with policy;

- All 37 FCC authorization WQs to evaluate volume and number of days a Referral or Authorization/Certification stays in the WQ;
- A sample of eight professional billing encounters and five hospital billing encounters from the WQ 2701 surgical procedures Reimbursement and Denial data file; and
- A sample of 15 events from the Cancelled and Rescheduled Events data file.

As part of our review we also visited two units (Ophthalmology and Pain Management) who manage authorizations in a decentralized manner, and performed limited review of WQs and orders for those areas. Those results are reported under separate cover. UC Managed Care authorizations were not included in this review since those are handled by the Managed Care Department.

Reports provided by the Revenue Cycle Analytics & Continuous Improvement team were limited to WQ 2701, designed for patient referrals for "Surgical Preadmission Authorizations Scheduled" as the initial version in this first phase of reporting. Additional reports will be developed for other service lines with specific WQs. Revenue Cycle Analytics & Continuous Improvement will expand on this for the other areas by using similar reporting on alternate WQs. There is an operational need from FCC and clinical operations for this type of data.

IV. CONCLUSION

Based on our review, we concluded that internal controls for authorizations for UCSDH services and procedures provide reasonable assurance that operations are effective, activities are compliant with relevant policies and procedures. However, we also noted some areas with opportunities for improvement with efficiency, reporting and communication.

FCC management has made significant improvements to business processes in the past three years since January 2020 under new leadership, including the development and documentation of standardized processes, procedures and guidelines for authorizations, and consolidation of WQs for efficiency and accountability. In addition, there is an organization-wide referral optimization project currently in progress to evaluate issues including ensuring departments are placing follow-up orders for return visits so there is sufficient time to secure an authorization. Documentation standards are in place and monitored by FCC management to gain assurance that quality standards are achieved. These standards have also been provided to several decentralized departments who have retained responsibility for processing their own authorizations. Revenue Cycle Management has initiated the formation of a Payer Authorization Steering Committee which will advise and recommend UCSDH systemwide goals, vision and best practices for authorizations. This committee will include representatives from centralized and decentralized departments is expected to begin meeting in June 2023.

FCC has implemented the use of a clinical override report and discussions with management in order to reduce the abuse of the clinical override cases. As a result, the number of patients being seen without an authorization on file has been reduced with improved usage of the override for medically necessary situations only. Management has indicated that with the authorization work that Revenue Cycle has completed, including the clinical override case improvements, FY 2021-2022 controllable losses were reduced by 15.4%, or $18.5 million, compared to FY 2020-2021.

During our review we noted opportunities for improvement with efficiency in securing authorizations, WQ management, reporting for denials and authorization key performance indicators (KPI), and quality control and performance monitoring processes in decentralized authorization departments. These opportunities for improvement are discussed in the balance of this report.

V. OBSERVATIONS REQUIRING MANAGEMENT ACTION

A.	Efficiency in Securing Authorizations
We noted that inconsistently documented and completed referral fields, insurance changes, missing current procedural terminology (CPT) codes, and inaccurate outgoing referrals created additional wasted workflow which affects timeliness and productivity for the FCC team authorization process.	
Risk Statement/Effect	
Inefficient processes can lead to late and/or denied referrals, resulting in poor patient satisfaction and customer service. In addition, a lack of training can lead to unresolved authorization-related issues that affect downstream revenue cycle processes and/or patient satisfaction.	
Management Action Plans	
A.1	FCC management is partnering with UCSDH Revenue Cycle Analytics & Continuous Improvement to review the authorization not required trends by payor or specialty and update the Auto Status Assignment (ASA) to reduce waste in WQs by redirecting referrals that do not require an authorization.
A.2	FCC management is finalizing the project with UCSDH Revenue Cycle Analytics & Continuous Improvement evaluating CPT mismatches between the actual authorization certification record and what was billed on the claim, with the goal to identify these in a WQ prior to claim submission.
A.3	FCC management has filled the advanced billing position that will be trained to assist the FCC team with authorizations for multiple specialties, researching denials, educating staff, reviewing WQs and reports.
A.4	FCC management will continue to provide authorization process training to new and current team members and float team members on insurance changes, standardized processes, outgoing referrals and any other areas of high risk or concern. Management should consider re-visiting the authorization boot camp.
A.5	FCC management will verify there are documented standard processes for critical pieces of the authorization workflow and staff are aware of these processes. This will include the review and streamlining of the Epic Insurance list if possible. Management will provide additional education or documentation of tips for staff to select particular payors when one payor has multiple options.
A.6	FCC management will reinforce guidelines for how long they delay a record according to the payor before they check it to see if anything is needed.
A.7	FCC management will review communication methods to reinforce to staff the different forms of communication related to authorizations using Epic In Basket, Outlook, Secure Chat or Microsoft

	Teams. These communication methods will be documented in formalized procedures and training including their expected usage based on the department, specialty and/or location.
A.8	The Payer Authorization Steering Committee will identify centralized and/or decentralized departments that require referral optimization, have documentation gaps, or have outdated standardized processes for improvement. As part of this process, FCC management and Revenue Cycle leadership will continue to provide guidance and best practices for all departments to implement.

A. Efficiency in Securing Authorizations – Detailed Discussion

The impact of inefficient or ineffective processes for obtaining authorizations is generally felt downstream in the revenue cycle, in particular in denied claims. Since the authorization process is connected to other functions, such as scheduling, insurance changes, and correcting missing or inaccurate CPT codes, the accuracy and timeliness of this process affects the overall workflow. One department may have specialists that work each of those components, while others may have specialists dedicated to only working one or more specific functions. User knowledge and an understanding of the relationship between each linked record, and the importance of the information entered in the data fields, are all key to ensuring records flow to the intended recipient for the next part of or completion of the process.

FCC management is currently partnering with Revenue Cycle Analytics & Continuous Improvement in the developmental phase of initiating reporting to determine the validity of the existing ASA table payor[6] language that determines 1) whether an authorization is warranted for services; and 2) whether auto-authorization is an option for the referral record.

Each time a provider submits a new referral, Epic automatically assigns a status to the referral based on the ASA table configuration. If the referral requires prior authorization or manual review, such as a referral for an inpatient stay, Epic assigns a status of “pending review” and the referral appears in a WQ for staff to review. This change will consider visit type, payor and CPT with the intent of altering ASA table logic to effectively reduce the manual touches Patient Access staff has to take on accounts. This work will continually evolve as more is learned from the payor denial posting patterns which will drive continued maintenance / optimization of the ASA table.

Manually reviewing referrals, obtaining prior authorization, and determining which services should be approved or denied is staff-intensive. To increase efficiency, workflows could be optimized to ensure that staff review only the complex referrals that require review. Improving automation and optimizing referral workflows can help free up resources to focus on other strategic initiatives. Also, overturning the referral ASA table in Epic to an approve-by-default model where every referral that doesn't match an ASA row is automatically authorized instead of pended which will keep the referral from falling into the WQ reducing the impact to Patient Access staff. The ongoing efforts between FCC and Revenue Cycle Analytics & Continuous Improvement are evaluating these issues.

[6] ASA payor configuration is an automation opportunity with the potential to reduce the number of manual touches required by the Authorization Coordinators.

Insurance Changes

During interviews we noted inconsistencies in workflows which impacts the processing of authorizations in Epic. FCC management stated that one of the most significant inefficiencies is when authorization coordinators must verify coverage for referrals more than once due to a change in the patient's insurance record. Any change to the coverage such as an effective date for a new plan or changing/adding insurance information will cause the account to drop back into the respective WQ to be verified again. In many instances there is no change in coverage, but since the record was touched the FCC must re-verify the coverage. Now that any area can make changes to the insurance, this is increasing the amount of errors and/or duplicative work.

In addition, we received feedback during our interviews that the Epic patient insurance list options were not updated, contained confusing titles and were too voluminous. Streamlining this process or providing an accurate, concise, and complete list of insurance providers, and definitions and training on how to select the correct plan should improve this process. Per the FCC Director, plan mapping has been built into Epic over the last two years, approximately 80% of the plans are mapped and over 70% are mapped uniquely or one-to-one which should eliminate employee estimation. The remaining approximate 20% percent is typically between two plans and there are available tools for staff on the FCC training teams pages to use to identify additional data pieces to make the appropriate decision. Additional focused education and in-service assistance may be beneficial for staff.

Missing or Inaccurate CPT codes

Missing information preventing the procurement of authorizations has been an ongoing issue for FCC. CPT codes are not always on the provider's order, or they may be inaccurate and the authorization coordinator has to determine the correct code. On occasion, the authorization coordinator will research and enter a code, but it could still be denied. There is a standard process documented for when there are missing/inaccurate CPT codes; however, during interviews we noted not all staff were aware of the process to complete when CPT codes are missing or inaccurate.

As part of the Revenue Cycle authorization denials reduction activities, there is a project currently underway to create a WQ to capture these referrals as soon as possible instead of waiting for a claim to be denied. Currently, the FCC authorization coordinators only know of an issue pre-service, when no codes are present in the referral or when a code in the referral does not match and/or relate to the procedure scheduled. At that point, the FCC team member will work with the ordering provider to correct the issue. There is not currently a report to trend the occurrence of this issue.

Per FCC management, the standard for FCC is to send incomplete referrals back to the ordering offices for review, with the expectation they update the missing or incorrect information. There are experienced staff who are able to easily and accurately identify which code should be used for a particular procedure and will make the correction avoiding additional wasted time. This is done based on information documented in the Epic chart, typically in a location other than in the referral where it should have been. When applicable, FCC staff will move information from one Epic section to another.

Standardized Authorization Process

Since the ambulatory clinic schedulers have not consistently followed the standard process of scheduling from a referral as defined by Revenue Cycle, appointments could be scheduled that do not have a linked referral. When this occurs, the FCC does not have visibility to the appointment if there is

no referral to be worked. As a result, WQs 17236 - 17239 and 17249 were created to identify appointments that do not have a linked referral and the FCC team communicates back to the departments on these trends. A team member must look to see if a referral is available and link it. This is accomplished by the team member doing one of the following:

- Open the WQ and manually linking the referral to the appointment, which routes it back to the authorization WQ to start the authorization process;
- Notify the department to link the referral or create the referral if it was never created;
- Manually create the referral for the provider; or,
- If it is an account that never requires an authorization, defer and partner with UCSDH Revenue Cycle Analytics & Continuous Improvement to create a rule to exclude that account from qualifying for these WQ's.

Regardless of whether the account requires an authorization, if the service requires a referral it is needs to be directed to the authorization WQ so the FCC team can update the referral authorization status appropriately to "approved – no authorization required". This further increases the workload for the FCC team and management to ensure that the authorization is secured, downstream billing and collections can proceed accurately, and the patient is not impacted.

FCC management is working with those areas with frequent corrections, such as surgery cases. Additional escalation of the downstream impact of inconsistent scheduling processes should be considered. Based on these identified areas, data elements including case orders and provider preference lists can be updated, and corrections made to the trend of missing information needed to reduce additional follow-up communications.

In addition, the Payer Authorization Steering Committee was recently established and expected to begin meeting in June 2023 with authority over authorization processes, including:

- Defining UCSDH best practices for authorization workflows;
- Identifying resources and defining projects to implement best practices;
- Approving exceptions to best practice;
- Creating KPI target recommendations to the executive board;
- Approving plans to implement systems and vendors related to authorizations; and
- Creating, publishing, and communicating policies related to authorizations.

During our interviews with decentralized departments should benefit from participation in and collaboration with the new Payer Authorization Steering Committee as they work to document and further standardize processes.

Inpatient CAT

Documentation for the overall inpatient authorization process and specific sections such as discharging patients and clearing the WQs was outdated; these sections have since been combined and streamlined so that the same individual works the account from admission to discharge. In addition, the documentation of the process performed by each team member would be helpful for cross-training. Other areas identified for internal controls improvement include documenting implementing guidelines for how long to delay a record based on the payor before determining if any additional information is required and an instruction/tip sheet on how to use online payor portals rather than making lengthy phone calls.

Training & Communication

There are four different methods of communication between the departments involved in securing authorizations which results in inconsistency. Team members can choose to use Epic In Basket, Epic Secure Chat, Microsoft Outlook, and Microsoft Teams. Consistency and training on methods and which ones to use when is key to effective communications. The Epic In Basket is an available tool that operates within the system which can select the account that an employee is communicating about by automatically attaching it to the current message. Individual service lines are allowed to choose their preferred method at this time, since the Epic In Basket does not work for all teams. Epic cannot distinguish which department is sending the message, and, as a result, one individual could be inundated with messages from all senders with no way to separate the messages without going through and reviewing each one, and transferring it to a separate basket. FCC management currently has a case opened with Epic to see if this functionality can be improved.

The complexity of the authorizations process, and the challenges described above highlight the need for comprehensive and continuous training in this area. In addition to the efforts described above, management could consider re-visiting the concept of an authorization boot camp which prior management considered in 2016. This could be of value for new and established Authorization team members in addition to members of other teams such as decentralized departments and scheduling.

B.	WQ Management
WQs need to be either updated, replaced and/or implemented to ensure effective authorization processes.	
Risk Statement/Effect	
Cases remaining in a WQ for longer periods can result in unmanageable WQs or unresolved authorization-related issues that affect downstream revenue cycle processes and/or patient satisfaction.	
Management Action Plan	
B.1	FCC management will continue updating and replacing central authorization WQs for the inpatient CAT and cleaning up old central authorization accounts that have been in a WQ over 90 days.

B. WQ Management – Detailed Discussion

During our review we noted several of the FCC WQs have either referrals or cases requiring action that have remained in the WQs for over 90 days, and some had a high level of overall cases. In addition, a significant portion of the Central Authorization WQs were out of date with stale accounts and/or required revision and/or replacement. After reviewing the WQ details, we noted that many referral WQs are inherited older WQs where the logic has not been updated. FCC's goal is to replace these WQs with new ones which will include only the work the CAT is responsible for completing. This work has started for Infusions and Ancillary Oncology with plans to next address CAT WQs and finally Radiology

Oncology WQs. Per management, these WQs tend to have a larger volume in January of each year for several reasons, including new insurance plan year coverage changes. Also, changes in Radiology protocols in August 2022 which allows patients to self-schedule certain magnetic resonance imaging (MRIs) and computerized tomography scans (CTs) and the inappropriate use of the STAT and Urgent statuses has negatively impacted these WQs. In addition, the WQ that captures orders with an appointment in the next 30 days with no referral link is worked as much as possible, however there were over 2,000 accounts in this WQ at the time of our review.

Inpatient CAT

We also noted opportunities to improve workflow related to Inpatient CAT WQs. We identified nine WQs referenced above that are inpatient CAT WQs that have a high volume of cases or cases that have been in the WQ over six months. Also, the department is working on process mapping for this WQ to identify how to reduce the volume. The CAT team is actively meeting to discuss issues, process mapping and identifying areas to fix. Also, to improve referral optimization, the CAT will review errors on accounts in the WQ while they have it open. If an account needs a discharge summary, or some other simple correction, that will be processed at that time so the account will not fall back to the beginning of the WQ.

C.	Reporting for Denials and Authorization Key Performance Indicators (KPIs)
Reporting has not been fully developed for authorization specific denials and key performance indicators.	
Risk Statement/Effect	
Lack of appropriate management reports can lead to inadequate decision making, responsiveness to issues and management effectiveness in addition to lost revenue and patient dissatisfaction.	
Management Action Plans	
C.1	FCC management has worked with UCSDH Revenue Cycle Analytics & Continuous Improvement to establish effective denial reporting on a consistent basis and a process for management to share those reports with the teams.
C.2	FCC management will continue to work with UCSDH Revenue Cycle Analytics & Continuous Improvement to establish lag-based reporting of authorization key performance indicators for all WQs in order to provide management with an effective reporting system to trend issues and manage the authorization process in addition to monitoring quality review.
C.3	The Payor Authorization Steering Committee and FCC management will assist in reinforcing training and reports available for decentralized authorization departments to utilize and manage denial and lag-based reporting for quality assurance and authorization management.

C. Reporting for Denials and Authorization KPIs – Detailed Discussion

Reports on denials and key performance indicators were not established to fully enable management review of trends and potential issues within the authorization process. UCSDH Revenue Cycle Analytics

& Continuous Improvement has recently created reports for the primary surgical procedures encounters in WQ 2701, however they have not been rolled out for all the authorization WQs.

Reports Provided by UCSDH Revenue Cycle Analytics & Continuous Improvement

Hospital Billing (HB) WQ2701 Reimbursement and Denial Detail Report

This report provides a summary of fully adjudicated zero-balance accounts from WQ 2701, to show denial frequency by category/code and NCR, which is the core metric for reimbursement identified by UCSDH Revenue Cycle management. NCR is a zero balance accounts-based KPI to evaluate the propensity to collect on a per-dollar basis by positioning payments versus expected reimbursement, excluding contractual adjustments. The NCR can indicate inefficiencies in the process; for example, if an area is struggling to collect payment due to bad debt, late filings, coding inaccuracies, claim underpayments or some other type of revenue issue, then it will have a low NCR.

The report utilized includes encounters that were released from WQ2701 between 1-1-22 and 12-30-22. Table 1 below shows a summary of all HB encounters that were processed for WQ2701 that were processed with no denial, denied and the corresponding denial categories and a total of the Authorizations team controllable denial categories. There are denial categories that the FCC and Authorization team have identified they have control over, including coordination of benefits (3), authorization (4) and registration/eligibility (5). In this sample of all HB accounts, there were 817 encounters with $41,644,189 in charges denied considered controllable by the Authorizations team (3+4+5)

Table 1: Hospital Billing – All Accounts

Denial Category / Remit Code	# of Accounts	Charges ($)	NCR %	Overall UCSD NCR %	Variance
No Denial **(1)**	17,459	$776,846,843	99.2%	98.2%	1.0%
Additional Documentation Needed	1,606	63,548,084	91.5%	94.3%	(2.7%)
Coding	643	19,907,052	83.4%	87.6%	(4.2%)
Coordination of Benefits **(3)**	435	21,311,843	96.1%	94.1%	2.0%
Authorization **(4)**	338	$ 17,292,562	85.3%	79.7%	5.6%
Medical Necessity/Level of Care	285	13,394,624	89.3%	84.6%	4.7%
Non-Covered	89	8,390,609	75.8%	85.5%	(9.7%)
Registration/Eligibility **(5)**	44	3,039,784	94.2%	96.2%	(2.1%)
Missing Claim Information	43	2,114,772	98.7%	97.5%	1.2%
Provider Enrollment/Credentialing	11	406,769	92.1%	82.8%	9.3%
Timely Filing	2	24,194	100.0%	99.5%	0.5%
Total Denials (2)	**20,955**	**$926,277,136**	**97.9%**	**97.3%**	**0.7%**
Total Denied Encounters Only (= 2 – 1)	3,496	149,430,293			
Total Controllable Denials (= 3 + 4 + 5)	817	41,644,189	**91.3%**	**97.3%**	**-6.0%**

Per management, the denial category “authorization” has encounters that are controllable by the Authorization team, but also many that are not. Overall, looking at only encounters that were denied, the FCC manages 23.4% of the volume and 27.9% of charges. We also noted there is a 91.3% NCR compared to 97.3% for UCSD overall.

We reviewed five HB accounts from the HB Reimbursement and Denial Detail Report that were denied at first, but subsequently reviewed and settled, with no exceptions noted. The Authorization team appropriately documented and updated that referral or authorization / certification using the new documented guidelines.

Professional Billing (PB) WQ2701 Reimbursement and Denial Detail Report

Table 2 below represents the same data as above, but for PB. This table represents all PB accounts with no denial, denial categories, and a total of the denial categories that the Authorization team has indicated control of, including coordination of benefits, authorization[7], and registration/eligibility. There were 149,597 encounters, with $127,161,089 in charges, and a 99.2% NCR compared to the UCSDH overall NCR of 98.4%.

Table 2: Professional Billing – All Accounts

Denial Category / Remit Code	# of Accounts	Charges ($)	NCR %	Overall UCSD NCR %	Variance
No Denial (1)	144,894	$119,792,373	99.7%	99.1%	0.6%
Additional Documentation Needed	2,028	3,774,001	97.2%	95.6%	1.6%
Coordination of Benefits (3)	1,185	1,142,210	97.1%	93.1%	3.9%
Medical Necessity/Level of Care	603	868,854	98.9%	94.9%	4.0%
Authorization (4)	386	685,800	58.0%	44.0%	14.1%
Coding	313	578,515	88.7%	87.1%	1.6%
Registration/Eligibility (5	104	205,954	99.5%	84.8%	14.7%
Timely Filing	55	103,942	72.3%	34.0%	38.4%
Provider Enrollment/Credentialing	29	9,440	100.0%	44094.2%	5.8%
Total Denials (2)	**149,597**	**$127,161,089**	**99.2%**	**98.4%**	**0.8%**
Total Denied Encounters Only (= 2 – 1)	**4,703**	**7,368,716**			
Total Controllable Denials (= 3 + 4 + 5)	**1,675**	**$2,033,964**	**79.4%**	**98.4%**	**(18.9%)**

Based on the above, there were 1,675 PB encounters with $2,033,964 in charges and a 79.4% NCR compared to the UCSDH overall NCR of 98.4% for those denial categories that management has indicated are controllable by the Authorization team. Overall, for these encounters that were denied, the FCC manages 35.6% of the volume and 27.6% of charges.

We reviewed eight PB accounts from the PB Reimbursement and Denial Detail Report that were denied at first, then reviewed and settled. The Authorization team appropriately documented and updated the referral or authorization/certification using the new documented guidelines for all eight out of the eight, with no exceptions noted.

Cancellation and Rescheduled Data Summary

Cancellation and Rescheduled data is defined by a delimited free text field which is a multiple response item based on the notes applied by Patient Access resources. Events with the free text field tagged "Fin/Ins Auth Not Approved" are considered to be related to authorizations. This data identifies case volume associated with an authorization-specific reason for either outcome scenario and determines an authorization-centric rate compared to the aggregate population. A summary of fiscal years 2020 through 2023 is as follows:

[7] As noted above, the remit denial category "authorizations" has encounters that are controllable by the Authorization team, but also many that are not representing the worst case scenario.

Rescheduled Events - 86,246 (total):

- 751 (0.9%) were authorization specific.
- 85,495 (99.1%) were not authorization specific.

Cancelled Events - 21,888 (total):

- 546 (2.5%) were tagged "Fin/Ins Auth Not Approved" as the reason field showing it was an authorization-related reason for the change of date of service.
- 21,342 (97.5%) cancelled events were for non-authorization related events.

We noted that the FCC can control the insurance element but not the schedulers or the training they have on which notes they select or why, as the schedulers have more control over and are responsible for rescheduling. Tables 3 and 4 below details the rescheduling and cancellation data summarized immediately above:

Table 3 Rescheduled Group	***2020***	***2021***	***2022***	***2023***	***Total***
Completed	**19,798**	**22,925**	**25,295**	**12,399**	**80,417**
Non Authorization Related	19,684	22,705	25,080	12,288	79,757
Authorization Specific	114	220	215	111	660
Not Scheduled			**103**	**139**	**242**
Non Authorization Related			99	137	236
Authorization Specific			4	2	6
Scheduled	**235**	**315**	**316**	**4,721**	**5,587**
Non Authorization Related	229	304	298	4,671	5,502
Authorization Specific	6	11	18	50	85
Overall Total	**20,033**	**23,240**	**25,714**	**17,259**	**86,246**
Authorization Rescheduled Rate	**0.60%**	**0.99%**	**0.92%**	**0.94%**	**0.87%**

Table 4 Cancellation Group	**2020**	**2021**	**2022**	**2023**	**Total**
Canceled	6,316	6,574	6,445	2,553	21,888
Non Authorization Related	6,164	6,419	6,287	2,472	21,342
Authorization Specific	152	155	158	81	546
Overall Total	6,316	6,574	6,445	2,553	21,888
Authorization Cancellation Rate	**2.41%**	**2.36%**	**2.45%**	**3.17%**	**2.49%**

Lag Report - WQ2701 Lag Indications

The recently developed lag report prepared by Revenue Cycle Analytics & Continuous Improvement is summarized below and provides an assessment evaluating the average number of days between each date-specific point in the referral workflow. The individual KPI's are defined below:

- Entry to Surge Days – Entry date to the surgery date of service.
- Entry to Touch Days – Entry date to the first touch from the FCC team.
- First Touch Surge Days – First day referral is touched to the date of surgery.

- Authorization (Auth) Surg Days – First day authorized to the date of surgery.
- First Touch Authorization Days – First day referral was touched to the day it was authorized.

The table below summarizes the lag indicators for FY2022 and FY2023 through November 30, 2022 by hospital service line:

Hospital Service	*Entry to Surge Days*	*Entry to Touch Days*	*First Touch to Surge Days*	*Auth Surge Days*	*First Touch Auth Days*
Cardiothoracic	*22.6*	*7.15*	*15.65*	*12.03*	*4.15*
Colorectal	30.77	11.55	19.45	16.73	3.19
ENT	36.92	18.49	18.63	13.52	5.56
Gastroenterology	57.91	21.40	36.63	35.25	2.20
General Surgery (Rad Onc)	30.21	13.04	17.36	14.38	3.58
Interventional Radiology	22.21	8.50	13.92	11.67	2.95
Neurosurgery	37.18	17.82	19.51	14.65	5.31
Orthopedics	39.54	11.79	28.31	18.69	10.13
Plastics	46.48	26.02	20.64	15.28	5.80
Reproductive Medicine	44.02	19.84	24.28	20.76	4.06
Trauma / Burn	30.85	14.62	16.34	12.42	4.41
Urology	28.88	13.88	15.15	13.16	2.69
Vascular	17.76	6.12	11.95	9.97	2.66
Grand Total	***34.26***	***14.63***	***19.83***	***16.04***	***4.36***

The authorization to surgery date is the core KPI (grey shaded column above). If there was going to be an issue with authorization, this is generally where it would be noticeable. FCC management has indicated that the average of 16 days is sufficient time to work on a denial or reschedule. The FCC management goal is to have all divisions at ten days or greater for this KPI, since it indicates how far in advance the authorization of the surgery is occurring. A lower authorization to surgery days ratio would be indicative of an issue since there might be insufficient time to work a denial or reschedule the surgery.

Decentralized Authorization Departments

Departments who manage authorizations in a decentralized manner did not receive denial or lag KPI reports. Instead they just receive a quarterly review of a denial report performed with Revenue Cycle that reflects the first reason for denial. The departments deal with accounts and issues as the problem arises and is brought to their attention. All units performing authorizations would benefit from routine denial data and lag reports so they can focus on known issues proactively.

D.	Quality Control and Performance Monitoring
The FCC has a number of reports that assist with monitoring quality control and staff performance, which are not available to decentralized departments.	
Risk Statement/Effect	

Lack of quality control and productivity monitoring can lead to poor staff performance, lack of motivation and inability to identify training and support needs.	
Management Action Plans	
D.1	FCC management will provide guidance on how to implement process for quality and performance monitoring in decentralized departments. This will be a part of the goals of the new Payer Authorization Steering Committee including full representation from all involved centralized and decentralized department currently being implemented by Patient Access.

D. Quality Control (QC) and Performance Monitoring – Detailed Discussion

The FCC has a number of reports that assist with monitoring quality control and staff performance, which are available to decentralized departments upon request and coordination with Revenue Cycle Analytics & Continuous Improvement . For example, the FCC monitors and measures productivity for its staff based on how many accounts were reviewed/processed by the WQ owner or authorization specialist. Productivity includes accounts submitted to insurance for authorization, or following up on an account that is pending. This data is compared with Healthcare Financial Management Association (HFMA) Industry Best Practice Standards and UC and industry averages. Productivity measures allow managers/supervisors to identify staff training or support needs. The use of quality data allows managers to analyze and review accounts marked as STAT or Urgent to analyze, address and isolate issues requiring immediate attention. QC allows managers to monitor the volume and type of accounts with STAT or Urgent designation, and also identify issues with a false or incorrect STAT or Urgent designation as those accounts would require top priority for the Authorization team.

Two decentralized departments we visited, Pain Management and Ophthalmology, did not have consistent processes for monitoring authorization staff productivity and quality control. This was, in part, due to a lack of reporting available for performance monitoring. Such reporting would be benefit for all units who manage decentralized authorizations. In addition, decentralized departments could use a report for QC to monitor the first priority cases, as well as denial data to identify areas of focus. Such reports would enable decentralized areas to better ensure compliance with the Patient Financial Policy requirement that securing of the authorization is standardized across UCSDH.