UNIVERSITY OF CALIFORNIA, DAVIS
AUDIT & MANAGEMENT ADVISORY SERVICES

UC Davis Health System, Urology Clinic
Audit & Management Advisory Services Project #16-36

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MANAGEMENT SUMMARY

Background

As part of the audit plan for fiscal year 2016 (FY16), Audit & Management Advisory Services (AMAS) conducted a review of the Urology Clinic (the Clinic).

The Clinic researches, diagnoses, and treats urological conditions in adult and pediatric patients. These conditions include urinary incontinence, urological cancers, kidney stones, male infertility, and other urological dysfunction. The Clinic's patient care office is located on the second floor of the Lawrence J. Ellison Ambulatory Care Clinic at UC Davis Medical Center (UCDMC); its administrative and academic office is on the third floor of that building.

The Clinic employs 12 senior physicians; 27 residents and researchers; 12 nurses and medical assistants; and 17 administrative staff. Management of the Clinic is divided between a Department Chair, who oversees research, education, and patient care; a Chief Administrative Officer, who oversees academic administration; and a Practice Manager, who oversees clinical operations.

The Clinic receives an estimated 17,000 outpatient visits per year. The School of Medicine's FY15 consolidated financial statements (SOM) report total Clinic revenue of approximately $3.8 million (including net technical revenue of $3 million) and total Clinic expenses of approximately $2.7 million in FY15 in its consolidated financial statements.

Purpose and Scope

AMAS conducted a review of business operations at the Clinic. The purpose was to determine the adequacy and effectiveness of internal controls and to evaluate compliance with relevant laws, regulations, and University policies and procedures. The scope included the following areas:

- Charge capture
- Cash handling
- Supplies, inventory, and controlled substances
- Security of protected health information
- Staff licensing
- Hazardous materials
- Vendor relations
- Issues related to the recent migration to Epic

AMAS held interviews with Clinic personnel and conducted limited audit tests, including site visits; review of financial ledgers, reports, and operating documents; observation of various work processes; and consultation with UCDHS entities such as the Offices of Compliance, Environmental Health & Safety, and the Pharmacy.

Summary Conclusion

Based on the results of the work performed, AMAS observed good operational controls overall:

- Clinic management has implemented procedures to ensure that supplies and inventory are secure;
- Staff licensing is up-to-date and individual staff members are given notice of upcoming renewal and continuing education requirements;
- Hazardous materials are stored and disposed of in accordance with relevant laws and UC policies;
- There is a strong separation of duties in the handling of cash;
- Staff are aware and compliant with University policy prohibiting acceptance of gifts from vendors.

AMAS also observed opportunities for the following controls and processes to be strengthened:

Charge Capture

- Timeliness – Though the Clinic's charge lag is improving, it is still in excess of the UCDMC goal of 4 days.

- Completeness - The Clinic is not submitting charges for all medical services rendered.

Protected Health Information (PHI)

- Notice of Privacy Practices (NPP) Acknowledgement Forms - NPP disclosure practices may not be compliant with HIPAA regulations.

- Authorization for Release of PHI - Clinic staff is unaware of the process required by UCDMC Policy for obtaining authorization for the release of PHI.

- Security of PHI on Clinic workstations – Some workstations in the Clinic's office areas may not be configured to the level of security required by UCDMC Policy.

Issues Related to Epic Implementation

- The FY 2015 UCDMC migration to Epic created uncertainty in staff at all levels regarding how to navigate the IT environment as necessary for maximizing job functions.

Security of Controlled Substances

- The Clinic is out of compliance with UCDMC Policy on the safekeeping of keys to its controlled substance lock-box.

OBSERVATIONS, RECOMMENDATIONS, AND MANAGEMENT CORRECTIVE ACTIONS

A. CHARGE CAPTURE

1. Timeliness of Coding

The Clinic's charge lag exceeds both the average for UCDMC clinics and the UCDMC charge lag goal.

Before the Clinic can submit charges for reimbursement to insurance providers, documentation of patient visits must be translated into standardized diagnosis, hospital, and professional fee codes. The lapse of time between a patient visit and the submission of these codes is referred to as a charge lag.

At the beginning of this audit in July 2015, the Clinic had a charge lag of 18.1 days. As of testing on November 9, 2015, the lag had been reduced to 13.19 days. This still exceeds the average UCDMC clinical outpatient lag of 11 days, and the system-wide goal of 4 days. The Clinic is working to reduce this lag, but it has not found a solution that is both workflow-efficient and cost-effective.

AMAS identifies coding capacity as a main cause for the charge lag. The Clinic employs one full-time PRA III. This level of staffing used to be sufficient to maintain an acceptable charge lag, but an increase in patient volume and a more time-intensive workflow created by the 2014 migration to Epic have made it difficult for the single PRA to meet Clinic productivity goals. As a temporary solution, the Clinic is utilizing a pool of float coders that is available through the Ambulatory Care Center (ACC). These float coders are PRA IVs and are paid at a higher rate than the PRA IIIs that clinics and UCDMC Centralized Coding hire to perform the same job. They are not, however, expert in coding for Urology.

AMAS suggests that Clinic management continue to work with the office of Clinical Operations to explore alternatives to the current staffing model. To aid in this, AMAS has researched the following options and provided a brief cost/benefit analysis of each: 1) the current model which utilizes a float coder; 2) new hire of an additional 0.5 FTE PRA III in-house; and 3) migration to Centralized Coding. The analysis is appended to this report as Exhibit A.

AMAS does however, acknowledge that the Clinic's current staffing model may be the most appropriate at the present. AMAS spoke with senior management in Clinical Operations, who shared concerns about the alternatives identified. These concerns are incorporated into Exhibit A. As a result, this report makes no specific recommendation in respect to PRA Staffing.

2. Completeness of Coding

The Clinic is not submitting charges for all medical services rendered.

AMAS observed that the Clinic is not submitting charges for all services in two distinct situations: 1) the Clinic's care providers are sometimes uncertain about what constitutes documentation sufficient to establish a right to bill; and 2) the Clinic never bills for administration of Lidocaine, though there are specified circumstances under which the Office of Compliance (Compliance) recommends doing so.

Sufficiency of Documentation. The Clinic's PRA must sometimes omit charges for services performed by ancillary staff because a signed physician order cannot be located. AMAS obtained a log of such omitted charges for a two-week period during the field work phase of this audit, and submitted it to Compliance. Compliance identified process improvements for more comprehensive physician orders, which will allow for similar services to be coded in the future.

Lidocaine. Lidocaine is an anesthetic used in various clinical applications. The Clinic is not currently billing for Lidocaine in any application. This practice reflects an outdated directive from Compliance. The current directive is to bill for Lidocaine in certain applications.

Recommendations

a. Clinic management should work with Compliance to implement process improvements that allow for more complete coding of ancillary services.

b. Clinic management should determine when it is appropriate to bill for Lidocaine, and communicate this information to its coding staff.

Management Corrective Actions

1. Compliance met with Clinic Management to recommend process improvements involving procedures requiring signed physician orders on 12/07/2015.

2. Clinic Management will implement process improvements based on Compliance's recommendations. This will include creating and distributing documentation of new mandatory processes to relevant staff and faculty, and conducting other training as necessary. This will be done by 02/15/2016.

3. Clinic management will meet with the Clinic's PRA to determine whether the new processes have successfully allowed for more complete coding of ancillary services. This will be done by 05/15/2016.

4. Clinic management will direct coding staff to use code J3490 to bill only non-Medicare payers for Lidocaine injected as a pain reliever. Lidocaine injected as a local anesthetic as part of a procedure, as well as application of topical Lidocaine, is bundled into procedure codes and should not be coded separately. This will be done by 05/15/2016.

B. PROTECTED HEALTH INFORMATION (PHI)

1. Notice of Privacy Practices (NPP) Acknowledgement

It is uncertain that the Clinic's process for collecting NPP acknowledgement forms is compliant with relevant law and policy.

UCDMC Hospital Policies and Procedures (HPP) 2406, "Notice of Privacy Practices", requires notice to be "posted and made available." Federal law (45 C.F.R. § 164.520) requires the clinic to provide notice of privacy practices to a patient no later than the date of first service delivery and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.

Our observations of Clinic procedures related to obtaining NPP acknowledgements indicate that while such acknowledgements were obtained, there may be opportunities to enhance the process to ensure consistency and compliance with applicable laws and regulations.

Recommendation

a. On a regular basis, Compliance conducts routine privacy reviews of UCDHS departments and clinics to ensure compliance with state and federal privacy laws and internal, privacy related policies. AMAS recommends that Compliance specifically include Urology in its annual privacy review, so that it may recommend solutions to any NPP acknowledgement issues unique to Urology, as well as those common among UCDHS clinics.

Management Corrective Action

1. Compliance will conduct a privacy review in the Clinic, including a review of the Clinic's NPP acknowledgement practices, as part of its system-wide review. This review will begin no later than March 1, 2016, and recommendations will be issued to the Clinic by May 30, 2016.

2. Release of PHI to Third Parties

Clinic staff is unclear on the HIPAA rules for releasing PHI to a third party.

HPP 2414, "Disclosing Protected Health Information (PHI) by Authorization" describes the requirements for an authorized release of PHI, including the requirement that the authorization be documented. Our observation of the Clinic's practices related to the release of PHI to a third party indicated that there is a lack of understanding of the elements that must be present to support such a release of PHI.

While observing Clinic operations, we witnessed an instance where a third party approached the patient check-in desk requesting to obtain a form of protected health information on behalf of a patient. The cashiering staff requested three pieces of identifying information, including the patient's full name, date of birth, and mailing address. When the third party provided these, the staff became willing to release the protected health information without the required authorization form. Nothing was released by the Clinic, because the requested materials were not found to be present there.

Recommendation

a. Clinic management should coordinate staff training to ensure that PHI is not released without proper authorization.

Management Corrective Action

1. Clinic management will require all staff who might be asked to release protected health information to complete UC Davis Staff Development and Professional Services' eLearning module #06528, "Privacy and Security Training." Staff who have already completed the training will complete it again as a refresher. The relevant staff will complete this training by 03/15/2016.

3. Security of PHI on Clinic workstations

Some workstations in the Clinic's office areas may not be configured to the level of security required by UCDMC Policy.

UCDHS IT recently began a project to implement security measures on Clinic office workstations. Because of changes in its staffing, IT discontinued this project before it reached the Urology Clinic. As a result, workstations in the Clinic may not automatically log users off after a period of inactivity.

UC Davis Policy and Procedure Manual (PPM) 310-22, Exhibit A, "UC Davis Security Standards", requires a screenlock to activate after a workstation has been idle for 20 minutes. This applies to all workstations within the Clinic's office areas, but excludes workstations in patient care and some research areas.

Recommendation

a. UCDHS IT should develop a plan to implement security settings on applicable Clinic workstations.

Management Corrective Actions

1. UCDHS IT Security will resume its screenlock enforcement project, beginning with the Urology Clinic. Workstations in the Clinic will be compliant with PPM 310-22 Exhibit A by 03/15/2016.

C. ISSUES RELATED TO EPIC IMPLEMENTATION

1. Inability to fully utilize Epic

Several members of Clinic staff expressed an inability to access useful reports within the Epic interface.

Staff and management reported that they do not regularly access reports related to their job functions. In some instances, the reason for this is that staff and management do not know how to generate the reports. In other instances, the reports are not available through Epic, though it may be possible for IT to create them.

This results in limited insight into clinical business operations where reports are not being consulted or are not available. Some examples include:

- Issues related to insurance eligibility, authorization, and denials
- Oversight of voided, cancelled, and otherwise modified transactions
- Deposit reconciliation

Recommendation

a. Clinic management should work with Clinic staff in the various roles to determine reporting needs. Management should communicate those needs to UCDHS IT.

Management Corrective Actions

1. Clinic management will develop a process for ascertaining and documenting the Epic reporting needs of Clinic management and staff. Clinic management will compile this documentation and share it with Clinical Operations by 05/15/2016.

2. After Clinic management has informed Clinical Operations of identified reporting needs, Clinical Operations will work with Clinic management to develop a comprehensive plan to provide reports by identifying existing information sources, utilizing the Clinical Operations report writer and/or working with UCDHS IT and begin implementation by 8/15/2016.

D. SECURITY OF CONTROLLED SUBSTANCES

1. Keys to the controlled substances lock-box

The Clinic is out of compliance with UCDMC policy on the safekeeping of keys to the controlled substances lock-box.

Keys to the controlled substances lock-box are kept on nurses' personal key rings and taken outside of the Clinic at night. This creates a potential for unauthorized duplication of keys, and thereby a risk of unauthorized access to controlled substances.

HPP 1210, "Controlled Substance Accountability for UCDMC Hospital-Based and Primary Care (PCN) Clinics", Section IV (F), governs the security of keys to controlled substance lock-boxes. It requires that:

- Access to controlled substance lock box keys will be limited to a minimum number of staff who are licensed or otherwise authorized to access controlled substances.
- Controlled substance lock box keys will be stored in a separate location in another locked storage area.
- Controlled substance lock box keys will not be taken outside the Clinic at any time, nor stored on any staff member's personal key ring.
- Failures in any of the above precautions will require the controlled substance lock box to be re-keyed and new keys made.

Recommendation

a. Clinic management should take action consistent with HPP 1210.IV (F).

Management Corrective Actions

1. Clinic management will take the following actions by 04/15/2016.

    - Purchase an appropriate key safe for storage of lock box keys
    - Inform staff, and enforce a policy that lock box keys be kept in the key safe when not in use.
    - Coordinate re-keying of the controlled substances lock box, and obtain two sets of new keys
    - Store one set of new keys in the key safe, which will be accessible to nursing staff; store one set of new keys in a locked storage area within the Practice Manger's office.

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EXHIBIT A: STAFFING OPTIONS

In the past, one PRA III was able to process all of the Clinic's charges on time. More recently, however, the Clinic has experienced an increase in its number of patient visits. In order to handle this increased workload, the Clinic is utilizing PRA IVs from the ACC float pool. Initially it was expected that these float coders would only be necessary temporarily, but it has become clear that the Clinic requires a more permanent staffing solution. Below are three possible models for a permanent solution:

I. The Current Staffing Model

Summary: The Clinic currently employs one full-time PRA III, and utilizes float PRA IVs as needed.
Benefit: The Clinic has coding staff in-house available to perform coding-related job functions, such as documentation training for care providers. There is a potential for float coders to be used less when not required, and the Clinic is only recharged for float hours actually used.
Disadvantage: Float coders are not specialized in one area, and so are not as efficient as dedicated coders. Float coders are paid at a higher rate than in-house coders.
Cost: Salary and benefits of one full-time PRA III; recharge of prorated fraction of PRA IVs' salary (but not benefits). The estimated monthly cost is:

1 FTE PRA III (based on data from DaFIS DS FIS339)

Salary	$5,500 (actual PRA III rate $33.10 X 166.6 hours, rounded)
Benefits	$3,700
Total	$9,200

Float PRA IVs (based on FY16 data from UCDMC Clinical Operations Finance Manager)

Recharge	$8,700

Estimated monthly total $17,900

Conclusion: The current staffing model is appropriate if the Clinic's need for staff in addition to the PRA III is temporary or varying. This model allows the Clinic flexibility to respond to varying workloads. If, however, workloads permanently exceed what one PRA can handle, then the clinic is paying a premium for an option that it will not be able to exercise.

II. New Hire of a 0.5 FTE PRA III

Summary: The Clinic could hire an additional 0.5 FTE PRA III, and discontinue utilization of float PRA IVs.
Benefit: The Clinic would have multiple PRAs in-house available to perform coding-related job functions, such as documentation training for care providers. An additional 0.5 FTE is expected to allow the Clinic to close its charge lag and maintain a charge lag consistent with the hospital goal. If workloads continue to increase, the clinic will have a trained 0.5 FTE coder whose hours can potentially be increased to meet demands.

Disadvantage: The Clinic will have committed to budgeting this amount for coding services. If workloads decrease, the Clinic will have to revisit the staffing question again. Some administrative burden will be involved, as creating an additional PRA position will require coordination with senior Clinical Operations management. Senior Clinical Operations management is doubtful that it will be possible to hire a PRA III at half-time. This position requires special training and certification, and it is uncertain whether a qualified applicant will be willing to accept part-time work.
Cost: Salary and benefits of one and one half-time PRA III. The estimated monthly cost is:

1.0 FTE PRA III (based on data from DaFIS DS FIS339)

Salary	$5,500 (actual PRA III rate $33.10 X 166.6 hours, rounded)
Benefits	$3,700
Total	$9,200

0.5 FTE PRA III

Salary & Benefits (PRA III mid)	$4,100

Estimated monthly total **$13,300**

Conclusion: This staffing model is appropriate if the Clinic is confident that the current workload will remain the same or slightly increase.

III. Migration to Centralized Coding

Summary: Centralized Coding is a service available to all UCDMC clinics. In a shift to Centralized Coding, the Clinic's PRA would move (both physically and for payroll purposes) to the office of Medical Services Abstracting. The amount that the Clinic would be recharged would reflect the actual hours required to code its documentation. The Clinic would not keep a coder on staff.
Benefit: Management in Centralized Coding has expertise in the area; closer, expert management would be expected to improve the timeliness, completeness, and accuracy of coding. PRA resources would be used more efficiently because staff would be directed to other areas of need when the Clinic's charge lag goals are met.
Disadvantage: The Clinic would not have a coder in-house to perform coding-related administrative functions, such as documentation training for care providers. In addition to the PRA's time, the Clinic would be recharged for a fraction of an Analyst's time. Senior Clinical operations management expressed a concern with current staffing issues in Centralized Coding, stating that a migration by the Clinic to Centralized Coding could negatively impact work flows across multiple hospital units.
Cost: Prorated PRA III salary and benefits, and a fraction of an Analyst's salary and benefits. Proration would be based on actual hours spent by PRA IIIs on coding for the Clinic. Thus the recharge amount would vary, based on the clinic's workload. The numbers below are based on the Clinic's current need of 1.5 FTE to code for 65 patient visits per day:

1.0 FTE PRA III (assuming the Clinic's PRA maintains same pay grade at move)

Salary	$5,500 (actual PRA III rate $33.10 X 166.6 hours, rounded)
Benefits	$3,700
Total	$9,200

0.5 FTE PRA III
Salary &
Benefits (PRA III mid) $4,100

7% fraction of an Analyst's time (provided by Central Coding Manger)
Salary &
Benefits $900

Estimated monthly total **$14,200**

Conclusion: This staffing model is ideal if the Clinic expects to experience a volatile workload, or if the expert supervision does in fact streamline coding enough to significantly reduce the amount of hours required for it.