UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
AUDIT & ADVISORY SERVICES

Medicare Advantage Denials
Project #22-024

February 2022

University of California
San Francisco

Audit & Advisory Services

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February 4, 2022

GIL RADTKE
Vice President of Revenue Cycle
UCSF Health

SUBJECT: Medicare Advantage Denials

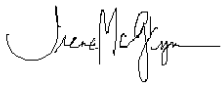
As a planned internal audit for Fiscal Year 2022, Audit & Advisory Services ("A&AS") conducted a review of Medicare Advantage Denials. The purpose of this review was to review controls to ensure consistency between payor contracts and billing and appropriate denial management procedures are in place.

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 review was completed and the preliminary draft report was provided to department management in December 2021. Management provided their final comments and responses to our observations in February 2022. 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. A&AS 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
Chief Audit Officer
UCSF Audit & Advisory Services

EXECUTIVE SUMMARY

I. BACKGROUND

As a planned audit for Fiscal Year 2022, Audit & Advisory Services (A&AS) conducted a review of Medicare Advantage denials. Medicare Advantage is another way to get Medicare Part A and Part B coverage; it is offered by Medicare-approved private companies that must follow rules set by Medicare. Medicare Advantage is a growing segment, and according to the Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 40% of Medicare beneficiaries were in a Medicare Advantage plan in 2020. During Fiscal Year 2020, UCSF collected approximately $134 million from Medicare Advantage payors.

II. AUDIT PURPOSE AND SCOPE

The purpose of this review was to review controls to ensure consistency between payor contracts and billing and appropriate denial management procedures are in place. The selection of the clinics to perform the review was based on several factors, including outpatient clinics with high Medicare Advantage net collections, large denials as a percentage of charges, and whether the clinic has been reviewed in recent years. The three clinics that were chosen are: 1. Ophthalmology-Vitreous/Retina, 2. Head and Neck Surg MB, and 3. Ortho Appliance ML.

Procedures performed as part of the review include: (1) interviewing key personnel to gain an understanding of the registration and authorization for Medicare Advantage, and procedures for following-up on denials or any request for information that were received; (2) interviewing Health Plan & Strategy Contracting to gain an understanding of key contract terms and requirements; (3) reviewed denials for appropriateness of follow-up and escalation including timeliness of response; (4) reviewed Medicare Advantage payors for which the UCSF does not have a contract with to ensure there is a Letter of Agreement (LOA) on file; (5) reviewed metrics and evaluate how they are being tracked, used and communicated; and (6) reviewed write-offs and trace back to denials to determine the root-cause and the appropriateness of the write-off.

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 November 2021.

III. SUMMARY

Based on the work performed, controls and processes for Medicare Advantage denial management appear to be adequate. Monthly, Medical Group Business Services (MGBS) meets with the clinics to present metrics such as: charge lag, days in Account Receivable, request for information report, denials, and write-offs. For the majority of the clinics, the information provided by MGBS is sufficient to monitor denials.

The specific observations from this review are listed below.

1. Letter of Agreements (LOAs) were not always obtained when UCSF does not have a contract with the payor, and the APeX Payor Plan listing does not always have the correct information on contracted status due to APeX system limitation.
2. Patient's insurance ID card is not always obtained and scanned into APeX and benefit plans selections are not always correct.
3. Authorizations are not always obtained prior to services.
4. A UCSF Health procedure on when a Patient Agreement of Financial Responsibility (PAFR) should be signed by the patient could not be easily obtained by the clinics.

IV. OBSERVATIONS AND MANAGEMENT CORRECTIVE ACTIONS ("MCAs")

<table>
<tr><th>No.</th><th>Observation</th><th>Risk/Effect</th><th>Recommendation</th><th>MCA</th></tr>
<tr>
<td>1</td>
<td>
Letter of Agreements (LOAs) were not always obtained when UCSF does not have a contract with the payor, and the APeX Payor Plan listing does not always have the correct information on contracted status due to APeX system limitation.

During the review, it was noted that LOAs were not consistently obtained by Head & Neck Surgery MB, and Ophthalmology-Vitreous/Retina. A report was produced for the last two fiscal years for visits when UCSF did not have a contract with the payor, and testing was performed to ensure a LOA was obtained. Please see table below for results. It was noted for Ophthalmology-Vitreous/Retina, there were six different visits from the same patient which had a LOA on file. For this one patient, it was noted that payment for the same service post-LOA was seventeen times greater than pre-LOA.

<table>
<tr><th>Clinics:</th><th># of Visits Without Contract with Payor</th><th># of LOAs Obtained</th><th>Compliance Rate</th></tr>
<tr><td>Ophthalmology-Vitreous/Retina</td><td>23</td><td>6</td><td>26%</td></tr>
<tr><td>Head and Neck Surg MB</td><td>6</td><td>0</td><td>0%</td></tr>
<tr><td>Ortho Appliance ML</td><td>0</td><td>N/A</td><td>N/A</td></tr>
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It was noted that the APeX Payor Plan listing had two Medicare Advantage plans described as "Unlisted" that were incorrectly shown as contracted with UCSF. As a result, no letter of agreement would be flagged in APeX for the clinic's registration team to obtain a letter of agreement with the payor. Additionally, system limitation did not allow specificity of contract status due to only having a single field available in the standard build that was used, but potentially having
</td>
<td>Without a LOA, UCSF may be paid based on the Medicare fee schedule which is substantially lower than the contracted rate.

Inaccurate information of a plan's contracted status with UCSF may lead to not obtaining a letter of agreement and thus getting a reduced rate.</td>
<td>Patient Financial Services should work with Health Plan Strategy to ensure the APeX Payor Plan listing has the correct contract status.</td>
<td>Action: Patient Financial Services has put in production an updated APeX Payor Plan listing and rules.

Responsible Party: Vice President of Revenue Cycle

Target Date: Completed</td>
</tr>
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No.	Observation	Risk/Effect	Recommendation	MCA
	different contract status between the Facility/Hospital and the Physicians/Medical Group.			
2	***Patient's Insurance ID card is not always obtained and scanned into APeX and benefit plan selections are not always correct.*** Head and Neck Surgery MB: One out of three denials related to authorizations did not have a scanned covered ID card by the time of the visit and had an incorrect benefit plan selected, leading to not getting the appropriate authorization. One out of fifteen write-offs was due to not selecting the correct benefit plan; therefore the clinic did not know that an authorization was needed. Ophthalmology-Vitreous/Retina: Five out of fifteen denials relate to not obtaining and scanning the covered ID card and so the incorrect benefit plan was selected, and one out of fifteen denials had the scanned covered ID card, but chose the wrong plan.	Without obtaining and scanning the coverage ID card, the clinic cannot ensure that the correct benefit plan is selected which can lead to an increase in denials and write-offs.	The clinic should communicate the importance of obtaining and scanning the coverage ID card at the time of the visit.	**Action:** Head & Neck Surgery MB has trained its staff to use Real Time Eligibility to register patients. **Responsible Party:** Director, Solid Tumor Practices, Cancer Center **Target Date**: Completed **Action:** Retina/ Ophthalmology clinic created standard work to collect patient's insurance card and check against existing information on APEX, so that insurance information is up to date **Responsible Party:** Director, Ophthalmology, Faculty Practice Organization

No.	Observation	Risk/Effect	Recommendation	MCA
				Target Date: Completed
3	***Authorizations are not always obtained prior to services.*** Ophthalmology-Vitreous/Retina: Two out of fifteen denials were due to the clinic not being aware that an authorization was needed for the payors. As a result, no authorization was obtained. Additionally, visits are not always scheduled as a correct type, leading to write-offs due to not obtaining authorization. Four out of fifteen write-offs were due to scheduling an incorrect appointment type (e.g., follow-up, or new visits and not procedure) and therefore no authorization was obtained.	Payors may deny payment for services as a result of not obtaining an authorization.	The clinic should develop a reference guide for which payors require an authorization. The clinic should train schedulers on how to identify the correct appointment type.	**Action:** Clinic created standard work to staff to schedule correct appointment type such as follow up procedure visit vs follow up so can be pre-authorized correctly by going to correct work queue in APEX. **Responsible Party:** Director, Ophthalmology, Faculty Practice Organization **Target Date**: Completed
4	***A UCSF Health procedure on when a PAFR should be signed by the patient could not be easily obtained by the clinics.*** Ortho Appliance ML: A PAFR is a signed statement which provides patients with an estimated liability for services. The PAFR transfers the financial liability to the patient when services are not covered by the payor. One out of fifteen denials were due to not having a PAFR signed and two out of fifteen write-offs were due to not having a PAFR signed.	Without a procedure around when a PAFR is needed, clinics are unclear as to when they should obtain one.	Information on when and how to obtain a PAFR should be easily accessible for clinics and relevant staff.	**Action:** Revenue Cycle will work with the APeX Access and Revenue Cycle Committee (AARCC) and clinic departments to update the PAFR form and tip sheet.

No.	Observation	Risk/Effect	Recommendation	MCA
	A PAFR procedure was created in 2018, but it was never posted to the Ambulatory website. It also incorrectly references a PAFR policy that does not exist, and clinics remain unclear as to when a PAFR should be obtained.			**Responsible Party:** Vice President of Revenue Cycle **Target Date**: June 30, 2022