

The logo for UC Irvine, featuring the text "UCIRVINE" in a large, serif font. A vertical line is positioned to the right of the text, separating it from the "INTERNAL AUDIT SERVICES" text.

INTERNAL
AUDIT SERVICES

Department of Anesthesiology

Internal Audit Report No. I2017-204

May 31, 2017

Prepared By

Larry Wasan, Senior Auditor

Reviewed By

Niran Joshi, Associate Director

Approved By

Mike Bathke, Director



INTERNAL AUDIT SERVICES
IRVINE, CALIFORNIA 92697-3625

May 31, 2017

SCOTT A. ENGWALL, MD
CHAIR
DEPARTMENT OF ANESTHESIOLOGY

RE: Department of Anesthesiology Audit
Report No. I2017-204

Internal Audit Services has completed the review of the Department of Anesthesiology and the final report is attached.

We extend our gratitude and appreciation to all personnel with whom we had contact while conducting our review. If you have any questions or require additional assistance, please do not hesitate to contact me.

Mike Bathke

Mike Bathke
Director
UC Irvine Internal Audit Services

Attachment

C: Audit Committee
Mona Wapner, Interim Chief Administrative Officer

I. MANAGEMENT SUMMARY

In accordance with the fiscal year (FY) 2016-2017 audit plan, Internal Audit Services (IAS) conducted a review of the School of Medicine's (SOM) Department of Anesthesiology (Anesthesiology), including clinic operations. In general, departmental controls and processes appear to be functioning as intended. Based on the audit work performed, some internal controls need improvement and should be strengthened to minimize risks, ensure compliance with University policies and procedures and/or best business practices. Specifically, the following concerns were noted.

Affiliation / Service Agreements – A physician did not have Board Certification in Pediatrics as required per the service agreement. Management from Anesthesiology, Contracting, and Medical Staff Administration did not know whether or not such certification was required by the organization with which UCI has the agreement. A change in compensation was also not documented in the amendment to the agreement. These observations are discussed in V.1.

Billing Timeliness – A large percentage of FY15/16 bills were being submitted for payment past the lag times required by management. Analysis of FY16/17 billing data showed significant improvements from FY15/16. However, further improvements are needed, and management is continuing to make changes accordingly. This observation is discussed in Section V.2.A.

Billing and Collections Policies and Procedures - The documented policies and procedures for billing and collections lack detail and certain pieces of information for best business practice. This observation is discussed in Section V.2.B.

Employee Separation - Separation checklists were not completed for a number of terminated employees, and requests sent to IT to deactivate systems access for separated employees were not timely made. This observation is discussed in Section V.3.

II. BACKGROUND

Anesthesiology is engaged to exclusively provide all anesthesia care services licensed at UC Irvine Medical Center. Anesthesia care is provided for the entire range of surgical specialties and sub-specialties, which includes general surgery, trauma surgery, urology, gynecology, obstetrics, plastics, otolaryngology, orthopedics, ophthalmology, neurosurgery, interventional radiology, neonatal surgical care, cardiac surgery, and thoracic surgery. Anesthesia coverage is provided 24 hours a day 7 days a week for approximately 30 anesthetic locations.

There are 183 employees in Anesthesiology, consisting of faculty, residents, fellows, Certified Registered Nurse Anesthetists (CRNA), Nurse Practitioners (NP), staff physicians, research staff and administrative support staff. There are 43 faculty (including clinical and basic science), 46 residents, seven fellows, 29 CRNAs, two NP's and five staff physicians, all of whom operate in the ORs with the exception of the basic sciences faculty.

All sources of income for Anesthesiology in FY15/16 totaled \$30.76 million, which includes professional fee income of \$19.7 million, resulting in a net profit of \$553,542. All sources of projected income for FY16/17 are approximately \$34.5 million, which includes fee income of approximately \$22.8 million with a projected net profit of approximately \$2 million.

III. PURPOSE, SCOPE AND OBJECTIVES

The primary purpose of the audit was to perform a general review of Anesthesiology and clinic operations to assess business risk, internal controls and compliance with University policies and procedures. The scope focused on certain operational and financial activities during FY1 2015-2016 and FY 2016-2017.

The audit included the following objectives:

1. Verify that the review of financial budgets and other financial reports were performed timely and documented;
2. Verify that expenses related to both restricted and unrestricted accounts are adequately monitored and that an adequate approval process is in place.

3. Review the methods to monitor service/affiliated agreements and verify they were properly approved, executed and terms were followed;
4. Assess the billing process and verify that patient charges were captured and billing was submitted timely and accurately;
5. Verify that collections were effectively managed and monitored;
6. Determine if controls surrounding personnel practices such as faculty leaves, performance evaluations and separation/termination were adequate and good business practice;
7. Verify that billing system access is adequately controlled and monitored;
and
8. Verify that adequate controls are in place to mitigate risks related to the handling of hazardous materials.

IV. CONCLUSION

In general, departmental controls and processes appear to be functioning as intended. However, business risks and internal controls and processes could be further enhanced in the areas of affiliated/service agreements, billing and collections, and personnel practices.

Observation details and recommendations were discussed with management, who formulated action plans to address the issues. These details are presented below.

V. OBSERVATIONS AND MANAGEMENT ACTION PLANS

1. Affiliation/Service Agreements

Background

Effective July 1, 2013, UC Irvine and an Anesthesiology physician signed an affiliation/service agreement with Children's Hospital of Orange County (CHOC). With the agreement, the UC Irvine physician filled the role of Director of CHOC's perioperative services research program "to manage, generally supervise and direct the medical administrative operations of the program". The physician also became Director of Training for the CHOC-UC Irvine Child Health Research Career Development Award to create a curriculum for training and developing early-career pediatricians. Per the original agreement, the physician's compensation from CHOC was \$150,000 per year, paid monthly at \$12,500.

Observation

A review of the above agreement revealed the following.

- The signed agreement required that the "Physician shall be board certified in pediatric Anesthesiology and Pediatrics prior to performing services hereunder. Physician shall provide proof of such certification to Hospital upon Hospital's request". Although the Physician is board certified in Anesthesiology, documentation obtained from management showed that his board certification in pediatrics expired in 2007, which was confirmed by the Medical Staff Administration office. As it currently stands, and unless further information is received by IAS to the contrary, this gap in certification is a non-compliance with the terms of the agreement and exposes the University to possible legal and financial liabilities.
- Effective July 1, 2016, the Physician's duties was changed and the compensation was reduced from \$150,000 to \$75,000 or \$6,500 per month. However, the reduction was not documented in the July 1, 2016 amendment to the agreement. For best business practice, amendments to signed agreements should be documented to avoid misunderstandings and to facilitate resolutions in case of legal disputes.

Management Action Plan

All affiliation/service agreements are prepared and executed by UCI Health Contracting Office. Anesthesiology has contacted the Contracting Office on several occasions to address the issues outlined above. Contracting is aware that the Physician's Board Certification in Pediatrics expired on December 31, 2007, and also confirmed that there is no written confirmation regarding the reduction in payment for FY 16/17. There are no payments overdue from CHOC, and the current agreement expires on June 30, 2017. The Physician has also been informed by CHOC that the agreement may not be renewed next fiscal year. Therefore, it is Anesthesiology's understanding that the Contracting Office is not planning to take any further action to correct these issues unless the agreement is renewed for another full year term, effective July 1, 2017.

2. Billing and Collections

A. Billing Timeliness

Background

Billing and collections are performed within Anesthesiology by a staff of three coders, four collectors, one insurance verifier, and one payment poster/analyst; all of whom, are managed by the Revenue Manager.

Interviews were conducted and policies and procedures were reviewed to gain an understanding of the billing and collections processes. Data analytics were also performed on FY15/16 and FY16/17 billing data to verify that scheduled anesthesia procedures had corresponding charges and that bills were submitted for payment timely. Delays in bill submissions for payment could result in an increase in payer denials, an increase in accounts receivables and a decrease in cash flow, and inefficiencies due to longer collection times and increased collection efforts.

Observation

Analysis of FY15/16 billing data revealed that a substantial percentage of bills from the various units of Anesthesiology (Anesthesia, Acute Pain, Regional Pain, Chronic Pain, and Critical Care) were being submitted after the 4-7 days

lag time set by management (See Chart 1 below). Analysis of FY16/17 billing data showed significant improvement in billing times (See Chart 2 below), and information obtained by IAS shows a corresponding improvement in the collection of accounts receivables. However, as shown in the statistics below, there is still room for improvements.

In Anesthesia, 12 percent of bills were submitted in FY15/16 between 8 and 30 days after the Date of Service, but improved to just 4 percent in FY16/17. Although 4 percent is within the satisfactory range, management has stated that they will continue to make improvements in billing timeliness for this unit.

In Acute Pain, approximately 62 percent of bills were submitted in FY15/16 between 8 and 30 days after the Date of Service, but improved to 51 percent in FY16/17. According to management, 10 percent would be satisfactory. Therefore, there is still room for improvement in billing times for this unit.

In Regional Pain, approximately 13 percent of bills were submitted in FY15/16 between 8 and 30 days after the Date of Service, but improved to 7 percent in FY16/17. According to management, 10 percent would be satisfactory. Although 7 percent is within the satisfactory range, management has stated that they will continue to make improvements in billing timeliness for this unit.

In Chronic Pain, almost 71 percent were submitted in FY15/16 between 8 and 30 days after the Date of Service, but improved to 41 percent in FY16/17. According to management, 10 percent would be satisfactory. Therefore, there is still room for improvement in billing times for this unit.

In Critical Care, more than 21 percent of bills were submitted in FY15/16 after the 30 day lag time set by management, but improved to 12 percent in FY16/17. However, the 12 percent was submitted between 121 and 180 days as opposed to 31 and 60 days for the 21 percent in FY15/16. Management stated that the longer lag times for this unit were due to delays from providers in submitting their procedures information to Billing. According to management, 20 percent after 30 days would be satisfactory. However, they have set a new goal of submitting bills within 7 days. Therefore, there is still room for improvement in billing times for this unit.

Chart 1: Fiscal Year 2015/2016 Billing Data

Percent of Bills Submitted in X number of Days after DOS					
	0-7 Days	8-14 Days	15-30 Days	31-60 Days	61-90 Days
Anesthesia	87.5%	9.2%	2.8%	.2%	.1%
Acute Pain	37.8%	43.5%	18.3%	.3%	0%
Regional Pain	86.9%	9.2%	3.9%	0%	0%
Chronic Pain	27.6%	50.2%	20.7%	1.5%	0%
Critical Care	4.9%	6.2%	67.2%	21.3%	.5%

Note: Highlighted percentages represent areas for further improvement. These bills were submitted past the lag time required by management.

Chart 2: Fiscal Year 2016/2017 Billing Data

Percent of Bills Submitted in X number of Days after DOS					
	0-7 Days	8-14 Days	15-30 Days	31-60 Days	121-180 Days
Anesthesia	96%	3%	1%	1%	0%
Acute Pain	49%	38%	13%	0%	0%
Regional Pain	93%	4%	3%	0%	0%
Chronic Pain	58%	32%	9%	1%	0%
Critical Care	12%	59%	18%	0%	12%

Note: Highlighted percentages represent areas for further improvement. These bills were submitted past the lag time required by management.

Management Action Plan

Ninety-six percent of Anesthesia claims are submitted within 0-7 days. The Billing Department continues to strive for 100 percent, but there will always be some delay while waiting for information on the case.

Acute Pain/Chronic Pain – needs improvement and processes have been put in place to remedy this. Previously, the providers were doing their own coding and this was causing a delay. The new process allows the Billing Department to abstract the coding from the providers' reports and complete their records.

Coding runs the pain schedules daily and emails the provider immediately if reports are missing. This reminder helps to make sure the reports are completed within the 7 day deadline.

Critical Care – The providers are also given a 7 day deadline for completing their documentation, but it is 7 days from when their work week is complete. The coders are now abstracting the reports and not waiting for encounter forms. This will speed up the process and improve billing lag days.

B. Billing and Collections Policies and Procedures

Background

A billing and collections policies and procedures document was obtained from management and was reviewed to verify that it includes information that is in accordance with best business practices. An effective policies and procedures document should contain enough detail for new staff members to follow in case of separation/termination of experienced staff. It should also be formally vetted and approved and contain the names of the document owner and approver, as well as dates of when it was effective and when it was last updated. In addition, policies and procedures should be stored where department policies are centrally located and available for review by staff members as needed.

Observation

The billing and collections policies and procedures document obtained from management appears to be informal and lacks detailed procedures for the various billing and collection functions, and it was not uploaded into the SharePoint site, where most, if not all, department policies and procedures are located. The document does not include information, policies and procedures, and/or links to documents (if available) related (but not limited) to the following:

- Charity Care/Financial Assistance, including policies regarding reasonable efforts to determine a patient's eligibility for financial assistance before engaging in collection actions to obtain payment;
- Customer Service Guidelines to ensure quality patient/customer care and to prevent harassment and abuse by collectors;

- Detailed policies regarding write-off, and eventual referral to collection agencies, of uncollectable balances over \$25, including dollar thresholds and required management approvals;
- Policy regarding patient account notations related to collection activities;
- Names of document owner and approver; and
- Dates of when the policy became effective and the last time it was updated.

Management Action Plan

The policies will be updated to provide formality and detail. When completed, the policies will be uploaded to SharePoint. This will be completed by June 30, 2017.

3. Employee Separation

Background

An employee separation checklist is available for use by management to ensure that all required steps for processing employee separations are completed and completed timely. These steps include HR and Payroll notifications, deactivation of systems access, return of University assets such as laptops, mobile devices, credit cards, and ID badges, timely processing of final paychecks, distribution of benefits documentation, etc. With regard to deactivation of systems access, *UC Policy Sec. 714-15: Policy on Access to University Administrative Information Systems* states, "Security access rights to specific (or all) administrative systems will be removed promptly for staff members whose assigned job duties have changed and who no longer require access to the specified campus administrative systems". To verify that separation checklists were completed by the department, IAS selected a sample of 10 separated employees for review. Five of the 10 separated employees were also reviewed to determine whether or not a timely request was made to Information Technology (IT) to terminate their systems access.

Observation

Of the 10 employees selected for review, four (40 percent) did not have separation checklists. Of the five former employees selected for review, although requests were made by management, all five requests to deactivate their systems access were made two to four days after their official separation

dates. These requests should be made prior to their separation dates to ensure that access is deactivated upon their separation.

Management Action Plan

Anesthesiology will ensure that the separation checklist will be completed on the last day of pay status and that University assets are returned at that time. A request will be submitted to IT services to deactivate the employee's systems access on the employee's final day on pay status. Attempts to deactivate an employee's systems access prior to his/her final day on pay status has led to early termination of that access resulting in the employee being unable to complete his/her assignments.