University of California
San Francisco

UCSF

Audit Services

August 22, 2014

ROGER CAMERON
Executive Director
Revenue Cycle
Patient Financial Services

SUBJECT: Denial Management
Project #14-035

As a planned internal audit for Fiscal Year 2014, Audit and Advisory Services conducted a review of Denial Management within Patient Financial Services (PFS). This review was completed in May 2014. 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 preliminary draft report was provided to management of PFS in June 2014. Management provided us with their final comments to our report in August 2014.

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.

The objectives of this review were to:

- Assess the adequacy of the internal controls in place for effective and efficient management of denials;
- Determine the effectiveness of the processes for denials prevention; and
- Evaluate the effectiveness of the processes for denial resolution.

Denials occur when insurance payers reject (refuse to pay) either the entire claim or the individual line items of a patient bill. Managing denials, identifying trends, and taking corrective actions are important for improving revenue and ensuring that the Medical Center is reimbursed for all services rendered.

Patient Financial Services (PFS) has responsibility for billing, managing, and collecting Medical Center revenue for inpatient and outpatient services provided throughout the UCSF provider network.

Two consulting groups, Huron in 2012 and Multi-Care in 2013, were brought in to improve revenue cycle operations, and aided in improving the denial management process as part of those efforts. Based on the consultants work, PFS implemented revised denial management processes and reporting. Between May 2013 and April 2014, avoidable denial write-offs totaled $140.3 Million. The breakdown of denials by the top five reason codes and type during the period May 2013 to April 2014 is shown below:

Top 5 Denials by Reason Code			
Code	Description	Amount	Count
16[1]	Lacks info needed for adjudication	$700,288,818	50,828
125	Submission/billing errors	$107,084,598	5,011
A1	Claim/Service denied	$73,205,290	4,505
96	Non-covered charges	$59,003,101	9,785
15	Authorization # missing or invalid	$56,452,199	4,907

To complete our assessment, we performed the following procedures:

- Reviewed the Billing Department Code, Reason Code Trends, and Average Write Off reports containing information on denials and write-offs to assess the oversight and monitoring of denials;
- Conducted further analysis by trending and analyzing the data contained in these reports in order to conclude on the effectiveness of the denial management process;
- Determined if root cause analysis was being conducted on denials and if this analysis was being documented in the issues log;
- Analyzed the issues log and reviewed trends in denials that had been identified in order to determine actions being taken were effective in reducing future similar denials;
- Interviewed staff involved in denial management in order to determine whether denials were being defined and tracked;
- Assessed the denial process to determine if management was following industry practices, and whether there were potential improvements that could be implemented;
- Analyzed write-offs due to untimely appeal and follow-up to determine if the denial resolution process was working efficiently;
- Reviewed a sample of 20 denials to determine if the processes for denial management were working as designed.

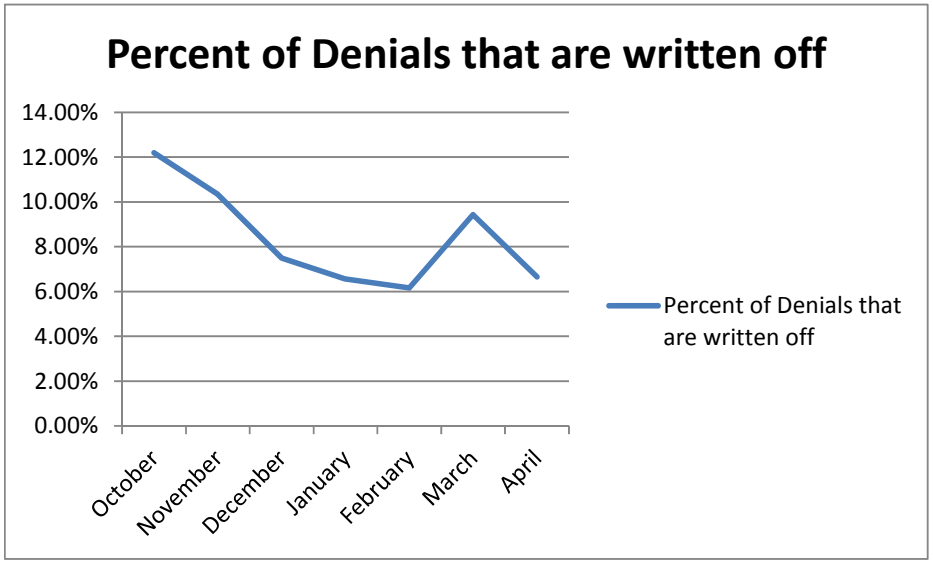
The scope of the review was limited to the specific procedures described above and related to transactions and activities occurring between May 2013 and April 2014. As such, work completed is not intended, nor can it be relied upon to identify all instances of potential irregularities, errors and control weaknesses that may occur in areas not specifically covered in this review. Fieldwork was completed in May 2014.

Based on our review, we noted that Patient Financial Services has put in place a variety of processes, procedures and technical tools to identify and manage denied claims and PFS is generally following industry practices for denial management, including:

[1] Reason Code 16 is used for a subset of related reasons and may not necessarily constitute a true denial as these claims may be paid with no additional actions taken by PFS.

- Integrating multiple groups into the revenue and denial management functions to enable better identification of trends and assignment of resolution;
- Communication to appropriate clinical and front-end departments to facilitate more timely resolution of denials;
- Tracking and trending rejections to identify on-going issues;
- Integrating denial recovery activities to improve efficiency and effectiveness of denial resolution;
- Monitoring write-offs and maintaining appropriate authorization levels for write-offs to improve revenue collection;
- Clearly defining roles, responsibilities and organizational structure for denial management for enhanced accountability;
- Integrating technology between clinical and revenue cycle process areas for enhanced communication;
- Implementing appeals process across departments for improved timeliness and effectiveness;
- Monitoring, measuring and reporting of denials for improved identification of trends;
- Improving communication/negotiation with payer to reduce non-preventable denials;
- Providing feedback on denials to appropriate back-end departments (Finance, Information System) for improved information and data reporting.

Since the current reporting and tracking process for denial management was put in place in October 2013, there has been an overall downward trend for both denials and write-offs. The percentage of denials being written off has decreased from 12% to 7% during the period October 2013 and April 2014 indicating effective appealing of denials.



Additionally, since October 2013, since Oct 2013 PFS has been tracking denials by type and focusing resources on the preventable denials.

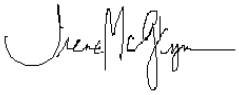
Denials between October 2013 and April 2014				
Type	Total	Preventable	Non-preventable	Undetermined[2]
Inpatient	$148,929,544	$71,076,545	$22,936,173	$54,916,826
Outpatient	$22,977,766	$15,272,167	$7,607,104	$98,495
Emergency	$463,943	$342,875	$113,138	$7,930

PFS should ensure that its efforts with the newly implemented denial management process are sustained. Additional process and control improvements identified by Audit Services that management should consider incorporating in their denials management workflow are as follows:

- Classifying all denials to ensure that complete data on preventability and owning areas for denials are captured;
- Providing feedback to the follow-up staff responsible for selecting owning areas, root causes, and preventability for denials when poor or missing selections are identified;
- Updating the UCSF Medicare Denial Procedures document to reflect workflows within APeX rather than IDX; and
- Setting performance goals and targets for denial management.

We would like to thank you and your team for all the assistance provided during the internal audit. Please do not hesitate to contact me at 502-2238 if you have any questions or require further information.

Sincerely,



Irene McGlynn
Director
Audit and Advisory Services

cc: Director Kwan
Ethics, Compliance & Audit Board Members

[2] Denials may not always be classifiable as preventable or non-preventable at the time of the denial due to lack of detail provided by payors or information being required from case management. Effective June 2014, a process was implemented to run the BDC Denial Owning Area Root Cause Report on a monthly basis prior to the report being finalized to identify and correct unclassified denials.