**UNIVERSITY OF CALIFORNIA, DAVIS**
**INTERNAL AUDIT SERVICES**

# University of California, Davis Health System
# Hospital Payer Reimbursement
# Internal Audit Services Project #11-16

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**Reviewed and Approved by:**

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# MANAGEMENT SUMMARY

## BACKGROUND

Hospital payer reimbursements were audited as part of planned reviews for FY11.

UC Davis Health System (UCDHS) has contracts with many different types of third party payers to provide medical services for patients covered under their health insurance plans. The types of payers include government programs such as Medicare, MediCal, Geographic Managed Care plans; and commercial payers such as Aetna, United Healthcare, and Blue Cross. There are many different methods of reimbursement for hospital charges, which are dependent upon the payer, type of service, and specific contracted terms. For example, Medicare inpatient cases are generally paid based on Diagnostic Related Groups (DRGs), while outpatient cases are paid based on Ambulatory Payment Classifications (APCs). MediCal inpatient cases are paid based on a per diem rate and outpatient cases are paid based on fee schedules. Commercial payers may pay based on a case rate, percentage of charges, per diem, DRG, or combination of per diem up to a certain dollar threshold then thereafter percentage of charges.

The Patient Financial Services (PFS) Department at UCDHS is responsible for ensuring the appropriate reimbursements are received for hospital services rendered and billed.

## PURPOSE AND SCOPE

The purpose of this audit was to evaluate controls over third party reimbursements posted to hospital accounts for accuracy and appropriateness.

To conduct our review we interviewed PFS personnel to determine the reimbursement methods for hospital services from third party payers and the processes and systems utilized to ensure the accuracy of reimbursements. We then used a risk based approach and focused our review on specific commercial payers and types of cases and reimbursement methods such as trauma, emergency, burn, stop loss, and coordination of benefits.

## CONCLUSION

Based on the results of our review, we conclude that internal controls are sufficient to provide reasonable assurance that reimbursements from third party payers are correct and in accordance with contracted terms. In order to accomplish this PFS has leveraged the use of computerized systems to automatically calculate expected reimbursements. Internal reviews are also performed by staff to confirm that reimbursements received are correct. Variance reports are generated and reviewed for problematic payers and case types. Furthermore an annual review is conducted by an external consulting group to identify underpayments. In addition, the department continues to further enhance the effectiveness and efficiency of calculating and verifying reimbursements through a roll out of a more robust contract management system that

can handle more complex reimbursement methodologies, reporting, and contract administration.

Based on our limited, sample review of specific types of cases and selected payers, we did identify over $221,000 in underpayments including $158,000 pertaining to six cases that were not identified as qualifying for Coordination of Benefits - Benefits Less Benefits (BLB) payments. There were three cases that qualified for a higher trauma rate reimbursement but were paid at a lower emergency or surgery rate that resulted in $48,000 in underpayments. In addition, there was one emergency case that was underpaid $14,000 at a lower stop loss rate. Our observations and recommendations are presented within the body of this report along with corresponding management actions.

## OBSERVATIONS, RECOMMENDATIONS, AND MANAGEMENT CORRECTIVE ACTIONS

### A. Coordination of Benefits Underpayments

**The review process to identify patient accounts that qualify for "Benefits Less Benefits" payments has not been consistently performed.**

Coordination of Benefits is a provision used to establish the order in which health insurance plans pay claims when there is more than one plan. "Benefits Less Benefits" (BLB) is a contract term that requires the secondary payer to pay as if they were the primary payer less what was already paid by the primary payer.

There are three opportunities for identifying cases that qualify for BLB payments that are billed to the correct payer and ensure appropriate collection occurs: 1) during the initial review by the PFS follow-up staff after each claim is submitted wherein cases that qualify for BLB payments are identified and flagged as such ; 2) during quarterly internal oversight reviews by different PFS staff than the follow-up staff using reports that identify accounts with a BLB, and 3) during an annual review of accounts deemed to be at greatest risk for underpayment by an external consulting group for a contingency fee of 25-30%. However, cases that qualified for BLB billing and payments were not being consistently identified and flagged as part of the initial review by the PFS follow-up staff. In addition, specific to UCD Managed Care capitated cases, the initial review by PFS follow-up staff is not performed and accounts flagged for BLB since patient account balances are auto adjusted to zero. Moreover, the reports of accounts with BLB payers were not consistently reviewed during 2010 and BLB qualifying cases identified because the employee responsible for this review was frequently absent for medical reasons.

We reviewed a judgmental sample of encounters with discharge dates in calendar year 2010 where the primary payer was a UCD Managed Care payer and the secondary payer was a payer that previous external consulting group reviews had identified with BLB underpayment issues. Our review identified 5 cases where the BLB payments were not identified where the primary payer was capitated with a total estimated underpayment of approximately $74,000. We also identified another BLB underpayment of over $84,000 for a non-capitated case. PFS has since appealed these cases and are awaiting payment.

#### Recommendations

1. PFS should catch up on the internal secondary oversight review of 2010 BLB cases and attempt to identify any BLB underpayments internally rather than have them identified by an external consulting group which charges a contingency fee of 25-30%.

2. PFS should ensure all cases including UCD Managed care capitated cases that qualify for BLB payments are identified and billed in a timely manner.

3. While a new process has been developed to ensure all qualifying BLB cases are identified and flagged for timely billing and routine follow-up review, PFS should continue to perform the quarterly internal oversight reviews of cases that qualify for BLB payments as a secondary check to ensure BLB claims are billed and payments are correct in accordance with contracted terms.

### Management Corrective Actions

1. The review of the January 1 - October 31, 2010 Inpatient Coordination of Benefits "Benefits Less Benefits" (BLB) cases has been completed. The review of the November 1 - December 31, 2010 Inpatient cases will be completed by May 15, 2011. The review of the Outpatient BLB cases is lower priority than follow up on primary payer balances, due to low dollar return expectations, but is underway. PFS expects to complete the Outpatient 2010 review by July 15, 2011.

2. PFS will ensure that all qualifying BLB cases including UCD Managed Care capitated cases are identified and flagged to ensure timely billing and follow-up. A report has been created as of March 29, 2011 that identifies all Inpatient and Outpatient accounts with a BLB secondary payer that were billed in the prior month. The report will be worked by clerical support staff to ensure all qualifying BLB cases are identified and flagged for timely billing and routine follow-up review. Qualifying Inpatient cases were flagged as of April 1, 2011. The Outpatient cases will be flagged by April 15, 2011.

3. PFS will continue to perform the quarterly internal oversight reviews of Inpatient cases that qualify for BLB payments as a secondary check to ensure BLB claims are billed and payments are correct in accordance with contracted terms. With the high volume and low dollar return expectations for outpatient cases and limited resources within PFS, the quarterly review will only be done for Inpatient cases. Review of the first quarter 2011 Inpatient BLB cases will be completed by June 15, 2011.

## B. Trauma & Emergency Cases Underpayments

Our sample review of trauma cases for selected payers with dates of service in 2010 identified 3 cases that were incorrectly paid at a lower rate than the trauma rate. The total underpayments identified were over $62,000. While there were underpayments, the processes in place for identifying and ensuring trauma cases are reimbursed correctly appears to be functioning well since our review only identified 3 underpayments out of 674 cases reviewed. PFS has already submitted appeals for the trauma underpayments and are currently awaiting payment. In addition, we identified 1 emergency case that was incorrectly reimbursed at a lower stop loss rate. PFS is currently in process of correcting this claim, which should result in additional reimbursement of $14,000. PFS indicated the cause of these underpayments were mainly due to human error.

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