September 4, 2019

LAURA HANDY-DINEEN
Executive Director
UC San Diego Health Revenue Cycle Administration
8911

Subject: ***Physician Receivables***
                         Report 2019-10

The final report for *Physician Receivables, Project 2019-10*, is attached. We would like to thank all members of the department for their cooperation and assistance during the review.

Because we were able to reach agreement regarding management action plans in response to the audit recommendations, a formal response to the report is not requested. The findings included in this report will be added to our follow-up system. We will contact you at the appropriate time to evaluate the status of the management action plans.

UC wide policy requires that all draft reports be destroyed after the final report is issued. We also request that draft reports not be photocopied or otherwise redistributed.

Christa Perkins
Interim Director
Audit & Management Advisory Services

Attachment

cc: David Brenner
         Judy Bruner
         Alex Bustamante
         Lori Donaldson
         Christopher Kane
         Brendan Kremer
         Patty Maysent
         Dennis Price
         Pierre Ouillet
         Mark Roberts
         Cheryl Ross

UC San Diego

AUDIT & MANAGEMENT ADVISORY SERVICES

Physician Receivables
Report No. 2019-10
September 2019

FINAL REPORT

Performed By:

Nai Hwang, Senior Auditor

Approved By:

Christa Perkins, Interim Director

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

Audit & Management Advisory Services (AMAS) has completed a review of Physician Receivables as part of the approved audit plan for Fiscal Year 2018-19. The objective of our review was to evaluate whether internal controls provided reasonable assurance that processes for managing Physician Receivables were effective, compliant with policies and regulations, and resulted in accurate financial reporting.

Based on our review, we concluded that internal controls provided reasonable assurance that processes for managing Physician Receivables were effective, compliant with policies and regulations, and resulted in accurate financial reporting. Physician Group Revenue Cycle processes related to billing, cash management, payment posting, credit balance recovery, and provider enrollment were well managed, and department staff were working to continually improve tools and documentation in these areas. We noted that processes for user access management appeared reasonable to ensure appropriate user templates and refund limitations were assigned. We also confirmed selected Dashboard Report figures traced to Epic system data.

We observed opportunities for improvement with respect to credit balance review for non-Medicare/Medi-Cal payors, and reconciliation of payment deposits by sources and Epic posting. We also noted that the Provider Enrollment Team is working on a standard provider enrollment procedure to better track enrollment processes. However, write-off transactions for services provided by physicians who were not fully enrolled and able to bill were not reviewed or approved. In addition, our review of billed transactions to the Fee Schedules identified some minor variances. Management Action Plans to address these opportunities for improvement are summarized below.

A. Credit Balance Oversight
1. The Credit Recovery Team will put additional focus through enhanced workflows on other government payors (non-Medicare or Medi-Cal) to improve timeliness of credit balance resolution.
2. The Credit Recovery Team will further optimize processes for managing non-government payor credit balances.
3. The Credit Recovery Team will transition credit refund check processes to Finance to eliminate the manual validation process.

B. Payment Posting Reconciliations
1. The Payment Posting Team will conduct expanded analysis to identify deposits by responsible parties to facilitate reconciliation of bank statements.
2. The Payment Posting Team is working with IS to obtain an Epic - Clarity report which will enable verification that payments deposited are posted to Epic patient accounts.

C. Provider Enrollment Practices
1. The Provider Enrollment Team has developed a more standard procedure for enrollment processes and utilizing a tracking log to ensure completeness of enrollment processes. Procedures will continue to be refined to optimize workflows.

> 2. Provider Enrollment management will revise processes for review and approval of these write-offs to ensure appropriate oversight and escalation.
> 3. Provider Enrollment management will communicate information regarding these write-offs to unit leadership as appropriate, and collaborate to minimize these write-offs to the extent possible.
>
> **D. Fee Schedules**
> The Billing Team will work with related departments to update incorrect rates, and ensure accurate and complete billing rates are maintained in the Fee Schedules.

Management agreed to all corrective actions recommended to address risks identified in these areas. Observations and related management action plans are described in greater detail in section V. of this report.

II. BACKGROUND

Audit & Management Advisory Services (AMAS) has completed a review of Physician Receivables as part of the approved audit plan for Fiscal Year (FY) 2018-19. This report summarizes the results of our review.

UC San Diego Health (UCSDH) Physician Group Revenue Cycle Department oversees physician professional fee billing, accounts receivables (A/R), payment posting, credit balance recovery, and provider enrollment processes for physicians in the UCSDH Physician Group. A total of 86 staff are organized into the following teams to support these functions:

- The Billing Team facilitates the processing of an average of 5,000 daily pre-bill transactions in the Epic Resolute system. Staff evaluate and resolve billing exceptions that can result from issues related to authorization, insurance coverage, coding, and other procedures. The Billing Team analyzes these exceptions, identifies common errors, establishes rules, and requests automatic edits in the Epic system. The Billing Team also works claim edits and denial transactions, identifies root causes, and develops management corrective plans in order to reduce controllable losses. In order to improve the effectiveness and efficiency of billing review processes, a Master Score Worksheet was implemented in November 2018 to prioritize billing/denial transactions based on defined criteria so that staff effort can be focused based on this prioritization. These criteria include the service date, billing date, denial date, number of outstanding days, number of available days for appealing, billing areas, specialty, and A/R billing amount. The Billing Team also provides physician professional fee billing services to University of California Riverside.

- The Payment Posting Team processes daily bank deposits and reconciles payment posting records in order to identify and resolve any discrepancies. A Master CPO[1] Reconciliation worksheet is used for tracking downloaded bank deposit records and reconciling to the posting entries.

- The Credit Recovery Team manages all credit balances and payor refund requests, with new refund correspondences averaging 3,000 per month. This team is focused on refund requests to ensure revenue is not automatically refunded without proper review. Each week, credit refund transactions are confirmed with Information Systems (IS) and Finance prior to issuance of refund checks.

- The Provider Enrollment Team is responsible for processing new providers which have cleared the credentialing process to submit required applications to government and private payors, establish their profile and provider identification number in Epic, confirm completion of training, and clear providers for billing for professional services. This team follows up with contracted health plans and government payors and completes roster validations to ensure patients can locate providers in the UCSDH network. The Provider Enrollment Team oversees about 1,800 providers. From January through May of 2019, 283 new providers were added to the enrollment list and an additional 600 new providers were expected to be added in June.

---

[1] The Physician Group was previously referred to as the Clinical Practice Organization (CPO), and some documents still use this term.

III. AUDIT OBJECTIVE, SCOPE, AND PROCEDURES

The objective of our review was to evaluate whether internal controls provided reasonable assurance that processes for managing Physician Receivables were effective, compliant with policies and regulations, and resulted in accurate financial reporting.

In order to achieve our objectives, we performed the following procedures:
- Interviewed the following:
  o Billing Team management and staff for billing processes, Master Score Worksheet methodology, user account management, and Dashboard review;
  o Payment Posting and Credit Recovery managers and staff for processes related to payment posting, reconciliation, and credit balance oversight;
  o Provider Enrollment manager for physician enrollment processes and oversight;
  o IS staff for system Cash reports and Fee Schedules updates;
- Reviewed UC Accounting Manual: H-576-6, Patient Account Receivables;
- Reviewed associated Policy and Procedure documents developed by Physician Group Revenue Cycle teams, including
  o Reconciliation & Payment Posting General Workflow Processes
  o Payment Processing & Reconciliation
  o Credit Recovery General Workflow Processes
  o Provider Enrollment General Processes
  o Absorption/Account Write-off
- Obtained and reviewed Professional Fee Schedules and Facility Fee Schedules;
- Traced physician billed amount to Fee Schedules for one selected billing file (368 transactions);
- Examined provider enrollment practices for a period of January through April 2019;
- Reviewed write-offs in Epic Work Queue (WQ) 736 due to incomplete provider enrollment for 2018 and 2019;
- Reviewed payment posting and reconciliation processes for April and May of 2019;
- Traced bank deposit amounts from Master CPO Worksheet to reconciliation worksheet and bank statements;
- Reviewed credit balance review and monitoring processes;
- Analyzed credit balance by payor and aging status in selected WQs for Undistributed and Overposted balances;
- Examined a sample of weekly credit refund confirmation emails and supporting documentation;
- Evaluated oversight for user system access; and
- Verified selected Dashboard Report figures to source data in Epic and/or WQ reports.

IV. CONCLUSION

Based on our review, we concluded that internal controls provided reasonable assurance that processes for managing Physician Receivables were effective, compliant with policies and regulations, and resulted in accurate financial reporting. Physician Group Revenue Cycle processes related to billing, cash management, payment posting, credit balance recovery, and provider enrollment were well managed, and department staff were working to continually improve tools and documentation in these areas. We noted that processes for user access management appeared reasonable to ensure appropriate user templates and refund limitations were assigned. We also confirmed selected Dashboard Report figures traced to Epic system data.

We observed opportunities for improvement with respect to credit balance review for non-Medicare/Medi-Cal payors, and reconciliation of payment deposits by sources and Epic posting.

We also noted that the Provider Enrollment Team is working on a standard provider enrollment procedure to better track enrollment processes. However, write-off transactions for services provided by physicians who were not fully enrolled and able to bill were not reviewed or approved. In addition, our review of billed transactions to the Fee Schedules identified some minor variances.

These opportunities for improvement are discussed further in the balance of this report.

V. OBSERVATIONS REQUIRING MANAGEMENT ACTION

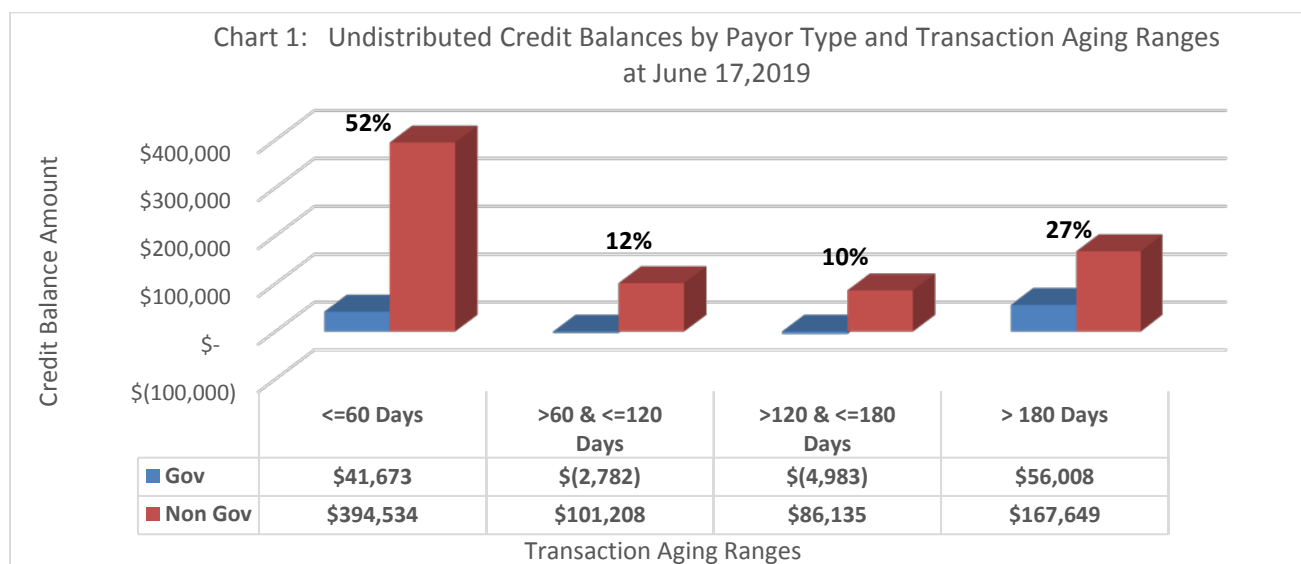| A.	Credit Balance Oversight
Processes for review of credit balances for non-Medicare payors could be improved to ensure timeliness of credit balance resolution. Weekly refund confirmation processes could also be enhanced to ensure confirmation of proper transaction count and dollar amount among parties.	
Risk Statement/Effect	
Ineffective credit refund processes could increase the risk of inaccurate or untimely credit refund transactions.	
Management Action Plans	
A.1	The Credit Recovery Team will put additional focus through enhanced workflows on other government payors (non-Medicare or Medi-Cal) to improve timeliness of credit balance resolution.
A.2	The Credit Recovery Team will further optimize processes for managing non-government payor credit balances.
A.3	The Credit Recovery Team will transition credit refund check processes to Finance to eliminate the manual validation process.

A. Credit Balance Oversight – Detailed Discussion

The UC Accounting manual: Medical Center, H-576-60, Part III; states "…*if the refund is to Medicare, the refund must be made within 60 days of the credit balance appearing on the accounts*." The Affordable Care Act, section 6402 (a) (42 U.S.C. section 1320a-7K (d)(1) also requires that recipients of Medicare and Medicaid funds who have received an overpayment must report and return the overpayment within 60 days when overpayment is identified. Recent government settlements have, in effect, applied this standard to other government payors, such as Tricare and the Department of Veteran's Affairs. Based on this, a best practice is to attempt to comply with this timeliness standard for all government payors. Standards for non-government payors may vary.

Credit Balance Processes

The Credit Recovery Team established a standard workflow and procedures to resolve credit balances, including evaluation of payor requests, refund, transfers, appeals, overpayment recovery and distribution activities. Staff work credit/recovery assignments by a priority hierarchy among designated Epic WQs. A Credit Summary Report is prepared daily to illustrate credit balances, which are classified in two categories: Undistributed (refund amounts) and Overposted (transactions which need to be reviewed to ensure proper overpayment recovery) by insurance or self-pay.

Undistributed Transactions Analysis

The Undistributed credit balance data (from 4 WQs)[2] as of June 17, 2019 was obtained and analyzed. Chart 1 shows credit balance transaction totals and aging interval for government payors and non-government payors.

Chart 1: Undistributed Credit Balances by Payor Type and Transaction Aging Ranges at June 17,2019

	<=60 Days	>60 & <=120 Days	>120 & <=180 Days	> 180 Days
Gov	$41,673	$(2,782)	$(4,983)	$56,008
Non Gov	$394,534	$101,208	$86,135	$167,649

Transaction Aging Ranges

Note 1: Debit amounts were noted which were classified in the Clearing Account with "CPO CLEARING,MEDI-CAL".
Note 2: Aging Days= Current WQ Entry Date (i.e. 10/9/2018) – Analysis Date (6/17/2019)

---

[2] WQ 716 - UC PB INSURANCE UNDISTRIBUTED; WQ 718 - UC PB CLEARING ACCOUNT CREDIT CATCH-ALL; WQ 8584 - UC PB INSURANCE UNDISTRIBUTED FROM VOIDED CHARGE; WQ 8596 - UC PB MEDI-CAL CIF PENDING RECOUP. Excluding transactions with Account Names coded with CPO Clearing – Incentive or Interest

We analyzed the aging for Undistributed credit balances, and noted the average aging for Medicare (247 transactions, $21,194) was 20 days, which is compliant with the policy and regulations. Aging for Medi-cal credit balances and other government payors were 197 and 145 days, respectively (see Table 1 below). We noted that the process for Medi-cal refunds was to submit a Claims Inquiry Form (CIF) to have a future claim off-set. The timing of the actual offset (and completion of the credit return) is impacted by Medi-cal review of these forms, therefore extending the aging of these credit balances. Credit balances requiring refunds to government payers should be approved after confirming that the credit balance was created by an overpayment.

There were 67 non-government payors with 5,050 transactions with an aggregate credit balance of $749,526, and an average aging of 157 days. Besides monitoring government payors overpayment transactions, a good business practice for credit balance oversight should also include review criteria and targets for non-government credit balances.

Table 1: Aging Analysis by Payors and Aging Ranges – Undistributed WQs (6/17/2019)							
Payor Type	<=60 Days	>60 & <=120 Days	>120 & <=180 Days	> 180 Days	Total Amount	Transaction Count	Average of Aging Days
MEDICARE	$ 21,115	$ 61	$ 17		$ 21,194	247	20
MEDI-CAL (3)	$ 2,742	$ (10,025) [2]	$ (9,670) [2]	$ 46,273	$ 29,319	1514	197
Other Gov Payors[1]	$ 17,815	$ 7,183	$ 4,670	$ 9,736	$ 39,403	552	145
Non-Government Payors	$394,534	$101,208	$ 86,135	$ 167,649	$ 749,526	5,050	157
Totals	$ 436,206	$ 98,427	$ 81,152	$ 223,658	$ 839,442	7,363	

(1)   Other Gov Payors include CALIFORNIA HEALTH & WELLNESS MEDI-CAL, CHAMPVA, MEDICAID - OUT OF STATE, MOLINA, TRICARE, TRIWEST, and VETERANS ADMINISTRATION.
(2)   Debit amounts were noted which were classified in the Clearing Account with "CPO CLEARING,MEDI-CAL".
(3)   Medi-Cal are not refunded. A Claims Inquiry Form (CIF) is required for future claim offset.

Overposted Transactions Analysis

Epic WQ 714 maintains majority of credit balance Overposted transactions. We analyzed payor type and aging ranges for this WQ, focusing on PxCode 208002000. Table 2 shows similar analysis when comparing with the Undistributed government payor transaction review. Aging days for Medicare (12 days) and Medi-Cal (41 days) were well below the 60-day standard, however aging for other government payors was above the standard. Credit balance review work should also extend to other government payors in addition to Medicare and Medi-cal.

Table 2: Aging Analysis by Payors and Aging Ranges – Overposted WQ 714 (6/14/2019)							
Payor Type	<=60 Days	>60 & <=120 Days	>120 & <=180 Days	> 180 Days	Total Amount	Transaction Count	Average of Aging Days
MEDICARE	$ 7,166				$ 7,166	113	12
MEDI-CAL	$ 27,054	$ 4,630	$ 8,621	$ 88,591	$ 128,897	11,190	41
Other Gov Payors	$ 58,479	$ 31,604	$ 47,853	$ 64,231	$ 202,167	2608	145
Non-Government Payors	$ 8,473	$ 62,666	$ 441,837	$ 695,273	$ 1,208,249	11,992	157
Totals	$ 101,172	$ 98,900	$ 498,312	$ 848,095	$ 1,546,479	25,903	

Credit Refund Transaction Confirmation and Summary Report

The Credit Recovery Team supervisor and manager review refund requests and audit staff work according to department guidelines to ensure consistency and work quality. Every Monday, IS provides transaction counts for credit balance refund transactions. Then, the Credit Recovery Team generates Epic Transmittal Reports which indicate the transaction count and dollar amount for refund transactions. The Credit Recovery staff validates transaction count with IS numbers, the Epic Transmittal Reports are then forwarded to Finance to issue refund checks.

We reviewed records related to this process and noted that the refund confirmation review for May 28, 2019 was not properly supported, as the supporting document totals for counts and amounts did not agree with the IS report. It appeared that staff had pulled Epic reports for the wrong date, however this discrepancy was not noted by the Credit Recovery Team or Finance before issuing the checks. When management re-ran the reports for the correct date, the data did match. During our review, we noted also that the credit refund audit process was behind schedule, and management planned to catch up audit work in June. The Credit Recovery Team is working with Finance to transition the credit refund check process, which will eliminate manual validation processes.

B.	Payment Posting Reconciliations
Downloaded bank deposit records were not reconciled to the monthly bank statements. Payment posting per bank deposit records was not confirmed with the Epic posting amount to patient accounts.	
Risk Statement/Effect	
Lack of timely reconciliation of payments received to the bank statements and Epic posting could result in untimely revenue recognition, denials, and payment adjustments.	
Management Action Plans	
B.1	The Payment Posting Team will conduct expanded analysis to identify deposits by responsible parties to facilitate reconciliation of bank statements.
B.2	The Payment Posting Team is working with IS to obtain an Epic - Clarity report which will enable verification that payments deposited are posted to Epic patient accounts.

B. Payment Posting Reconciliations – Detailed Discussion

The Reconciliation Team downloads previous-day deposits from the banking partner website into a "Master CPO Bank Recon" worksheet. Then, staff review and code payments by type and payors. A Daily Log tab maintains reviewed deposits, which are then ready for the Payment Posting Team to evaluate. Payment Posting staff work on assigned WQs to post edits, follow up with payors, and provide batch information back to the Reconciliation Team. The team management assists with reconciliation and payment posting processes, follows up on outstanding remittance files, audits accounts; and provides reports to leadership. Our review of the Daily Log (January – April 2019) for payment posting noted that adjustments were properly noted and commented.

Bank Statements Reconciliation

We noted that while bank deposit records were downloaded daily, there was no routine verification of the daily downloaded records to the monthly bank statements. During our review, the Payment Posting Team developed a reconciliation approach that reconciled April's Master CPO Bank Recon worksheet to two bank statements, totaling $30.3 million. The team is working on the reconciliation for May, totaling $58.9 million. Reconciling the daily records to monthly statements would confirm the accuracy and completeness of deposit transactions to UCSDH Physician Group accounts.

Epic - Clarity Posting Reconciliation

We also observed that current procedures did not ensure all payment deposits were posted to the Epic patient accounts. Differences could be due to timing differences, incorrect pay codes, payments with no remit information, refunds/transfers/denials not belonging to Physician Group, research payments, and/or voided charges. Epic - Clarity posting reports could capture all posted transactions to enable a standard reconciliation from payment deposited to bank accounts and patient accounts posting. This would provide better assurance that all payments were posted to patient accounts or other non-patient accounts. The team is working with IS to develop an Epic - Clarity report that will show a total patient posting in Epic which should be able to match with bank deposits received.

C.	Provider Enrollment Practices
Write-offs resulting from services provided before providers were fully enrolled did not evidence documentation of management review and approval.	
Risk Statement/Effect	
Incomplete provider enrollment processes and write-offs without appropriate management review could increase risk of loss revenue.	
Management Action Plans	
C.1	The Provider Enrollment Team has developed a more standard procedure for enrollment processes and utilizing a tracking log to ensure completeness of enrollment processes. Procedures will continue to be refined to optimize workflows.
C.2	Provider Enrollment management will revise processes for review and approval of these write-offs to ensure appropriate oversight and escalation.
C.3	Provider Enrollment management will communicate information regarding these write-offs to unit leadership as appropriate, and collaborate to minimize these write-offs to the extent possible.

C. Provider Enrollment Practices – Detailed Discussion

Provider Enrollment Tracking Log

At the outset of our review, there did not appear to be established processes for tracking and monitoring of provider enrollment steps to ensure the timely completion of each step. In April 2019, a new manager was hired to lead the Provider Enrollment Team. This manager developed a new Tracking Log to monitor tasks for each key step in the process, including obtaining provider information, billing profile set up, notification to various insurance or government payors, enrollment dates with various applications, effective/approval dates with health plans, and compliance training registration. Three key dates should be tracked and signed off when completing enrollment for a new provider:

- Physician Group management sign off date – as an effective date;
- Enrollment date in Medicare (PECOS) application; and
- Notification to appropriate Health Plan for Tax Identification Number.

From all these date fields, major process measurements could be calculated and established for future improvement. These process measurements include time from provider package received to start date, time from credential committee to various insurance application approval, time from package received to complete, and time from credential committee to complete. To ensure the consistency and quality of provider enrollment processes, the team supervisor is developing desk procedures to standardize workflows for staff.

Write-Offs

Medical services provided before provider enrollment date cannot be billed to insurance or government payors. Epic WQ 736 captures write-off transactions due to services provided prior to provider enrollment date. Table 3 summarizes the total transaction count and write-offs amounts from 2018 and 2019 (as of May), and Table 4 provides additional detail for 2019 write-offs.

Table 3: WQ736 Write-Off – Provider Enrollment				
Year / List Amount	Count of Medicare	Sum of Medicare	Count of Medi-Cal	Sum of Medi-Cal
2018	2	$ 43,327	16	$ 86,777
2019 (Jan- May)	5	$ 40,469	6	$ 41,207
Grand Total	7	$ 83,796	22	$ 127,984

Source: Provider Enrollment Tracking Log

Table 4: WQ 736 Write-Off January – May 2019 by Specialty				
Specialty	Count of Medicare	Sum of Medicare	Count of Medi-Cal	Sum of Medi-Cal
NEUROSURG	2	$ 39,665	3	$ 40,230
FAMILY PRACTICE			1	$ 355
NEUROLOGY			1	$ 345
MENTAL HEALTH	1	$ 136	1	$ 277
EMERGENCY MED.	2	$ 668		
2019 (Jan - May)	5	$ 40,469	6	$ 41,207

We noted that write-offs for professional services provided prior to completion of provider enrollment did not evidence management review and approval.

Lack of write-off review and approval could result in lost revenue and missed opportunities in identifying areas for improvement in provider enrollment processes. Timely review of write-off transactions could assist in communicating with provider's department to identify causes and possible corrective actions and minimize future write-off amounts. Currently, the team supervisor is identifying WQs associated with provider enrollment processes, clarifying responsibilities for those WQs, and developing monitoring procedures.

D.	Fee Schedules
We noted some instances where billed amounts did not agree with the Fee Schedules, or billed CPT codes were not included in the Fee Schedules.	
Risk Statement	
Incomplete Fee Schedules or incorrect billed amounts could increase risk of inaccurate physician fee billing and loss revenue.	
Management Action Plan	
D.1	The Billing Team will work with related departments to update incorrect rates, and ensure accurate and complete billing rates are maintained in the Fee Schedules.

D. Fee Schedules – Detailed Discussion

Two fee schedules (Facility and Non-Facility) were maintained for physician professional fee billing. These fee schedules were reviewed and updated in FY2017/18. Management plans to conduct a review of the fee schedules periodically as business needs dictate, with ad-hoc review as needed or requested.

We reviewed a sample billing file (368 billing transactions) and traced to the fee schedules to evaluate for physician billing rates are charged. We identified one instance where a billed charge did not agree to the fee schedule, and five instances where CPT codes were not included in the fee schedule, as indicated below:

Type 1 - Billed Charges Not Agreed with Fee Schedules (one transaction)					
CPT Code	Service	Bill Area	Service Date	Unit Charges	Billed Charges
24538	PB PERCUT FIX HUM SUPRACONDYLAR FX	Anesthesia	9/27/2018	$ 3,049	$ 1,300

Type 2 - CPT Codes Not Included in the Fee Schedules (five transactions)					
CPT Code	Billed Amount	Bill Area	Procedure	# of Billing Transactions	Service Month
J7999	$ 80.00	OPHTHALMOLOGY	80482	2	October 2018 January 2019
V2718	$ 30.00	OPHTHALMOLOGY	12187	2	February 2019
V2718	$ 60.00	OPHTHALMOLOGY	12187	1	February 2019