

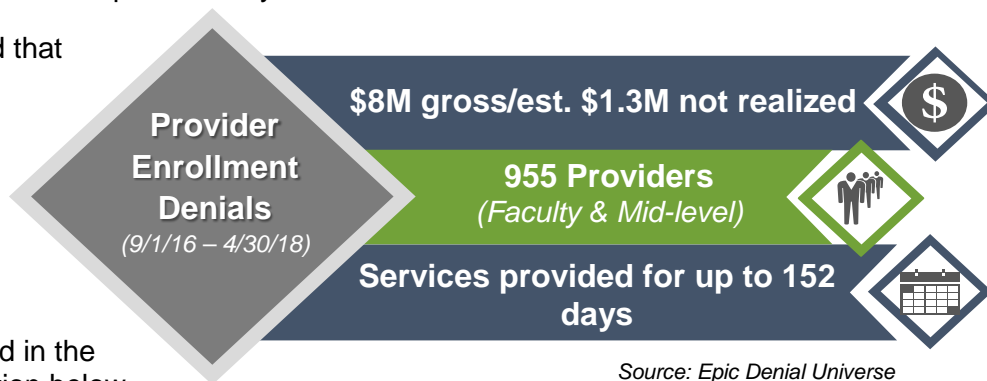
18-116 Provider Payor Enrollment

EXECUTIVE SUMMARY

Provider enrollment is the process by which the institution enrolls providers to participate in payor insurance plans, so that the institution can be paid for services rendered to patients. When a provider is not enrolled prior to services being rendered or enrollment lapses, denials will occur, resulting in lost revenues. At the time of our review, Patient Business Services (PBS) managed provider enrollment for over 2,300 providers.

In summary, for the period in review, \$8 million in gross patient revenue was captured, billed and subsequently denied because providers were not enrolled with Payors at the time services were provided. The cash collections not realized was \$1.3 million. These denied claims involved 955 individual providers. The providers' enrollment was deactivated, and they continued to provide services for up to 152 days.

Our assessment indicated that providers are periodically deactivated or placed on hold. Because of this, proactive monitoring of each provider's enrollment status is necessary.



Further details are outlined in the Detailed Observation section below.

Management's Summary Response:

Management agrees with the observations and recommendations and has developed action plans to be implemented on or before December 31, 2018.

Appendix A Outlines the methodology for this project.

Appendix B Provides detailed charts

The courtesy and cooperation extended by the personnel in Patient Business Services and Medical Staff and Credentialing is sincerely appreciated.

Sherri Magnus

Sherri Magnus, CPA, CIA, CFE, CRMA
Vice President & Chief Audit Officer
July 2, 2018

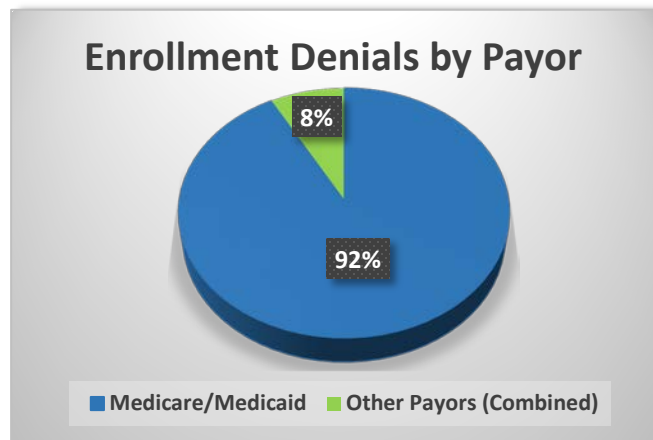
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DETAILED OBSERVATION

Observation 1
Monitor Provider Payor Enrollment

RANKING: Moderate

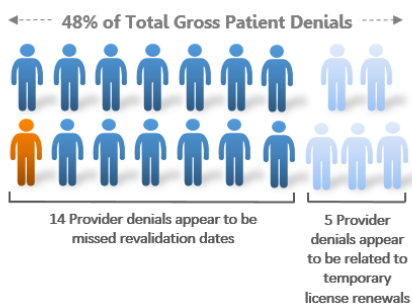
During our review, we analyzed denials resulting from providers not being enrolled with a payor. We noted \$8 million in gross patient revenue captured, billed and subsequently denied, due to a lack of monitoring of enrollment status. Based upon average Medicare/Medicaid collections, this represents a probable loss of \$1.3 million. Further analysis indicated that the top 19 providers with \$100,000 or more in denials (48% of total gross patient revenue) involved primarily Medicare denials, while one provider had primarily Medicaid denials. The denials for the top 19 providers resulted from:



Source: Epic Denial Universe

- *Missed revalidation dates for 14 (13 Medicare, 1 Medicaid) providers* - Exceptions occur because Centers for Medicare and Medicaid Services (CMS) does not consistently provide reminders or alerts of pending enrollment expirations. This information, however, is often available on the CMS or Novitas websites.
- *Untimely temporary license renewals for five providers* – Exceptions occur because license renewals are not submitted to Payors prior to expiration although expiration dates are on file. Lack of coordination between Medical Staff and Credentialing and Patient Business Services contributes to this issue.

TOP 19 PROVIDERS WITH \$100K OR MORE IN DENIALS



Providers with primarily Medicare denials
 Temporary license renewals, primarily Medicare
 Providers with primarily Medicaid denials
 Total Medicare denials for top 19 providers: \$3.4 million
 Total Medicaid denials for top 19 providers: \$200K
 Total Managed care denials for top 19 providers: \$10K

Providers must be actively enrolled with Payors in order for patient charges to be eligible for reimbursement. When payor enrollment is not monitored, providers can be deactivated resulting in lost revenue.

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Recommendation:

Management should proactively monitor the provider enrollment status in each Payor plan to ensure enrollment does not lapse.

Management's Action Plan:

Responsible Executive: Miriam Flores

Owner: Jessica Campbell

Due Date: January 31, 2019

ECHO, the software application used by Medical Staff & Credentialing, has not been maintained or reviewed for better system visibility until recently.

Discoveries in the last six months have revealed a Provider Enrollment Module within ECHO that would facilitate the monitoring function for PBS. We are working with the Medical Staff and Credentialing Office to implement the provider enrollment module of ECHO/Verity to replace the current manual spreadsheets. This will provide a tool to monitor enrollment status to help ensure provider enrollment is kept up to date. PBS will continue our collaboration with the Medical Staff & Credentialing Office throughout the year with focus on people, processes and technology opportunities.

Provider enrollment application responses from providers or department administrators are incomplete or untimely.

PBS has subsequently implemented a process to copy the department administrator with the first e-mail to the provider and escalate to the division administrator or department chair as appropriate if responses are not received timely. PBS will provide education sessions to the department administrators regarding provider enrollment and emphasize the importance of these applications.

Appendix A

Objective, Scope and Methodology:

The objective of this engagement was to provide an assessment of the Provider Payor Enrollment. This included gaining an understanding of the enrollment process and performing data analytics for denial code B7 (provider enrollment denial code). This review covered the period of September 2016 to April 2018, and any related periods. Of note, is the EPIC go live in March 2016 and the audit timeframe covers EPIC post implementation stabilization.

Our procedures included the following:

- Interviewed key personnel within Patient Business Services and Medical Staff and Credentialing, to gain an understanding of the Provider Payor enrollment process.
- Utilizing data for denial code B7, performed analytics to evaluate and assess the data, to identify where most denials are occurring, by whom and by which Payors.
- Documented the Provider enrollment process from initial enrollment to revalidation.
- Reviewed Medicare and Novitas websites for enrollment and revalidation information.

Our internal audit was conducted in accordance with the *International Standards for the Professional Practice of Internal Auditing* and *Government Auditing Standards*.

Number of Priority Findings to be monitored by UT System: None

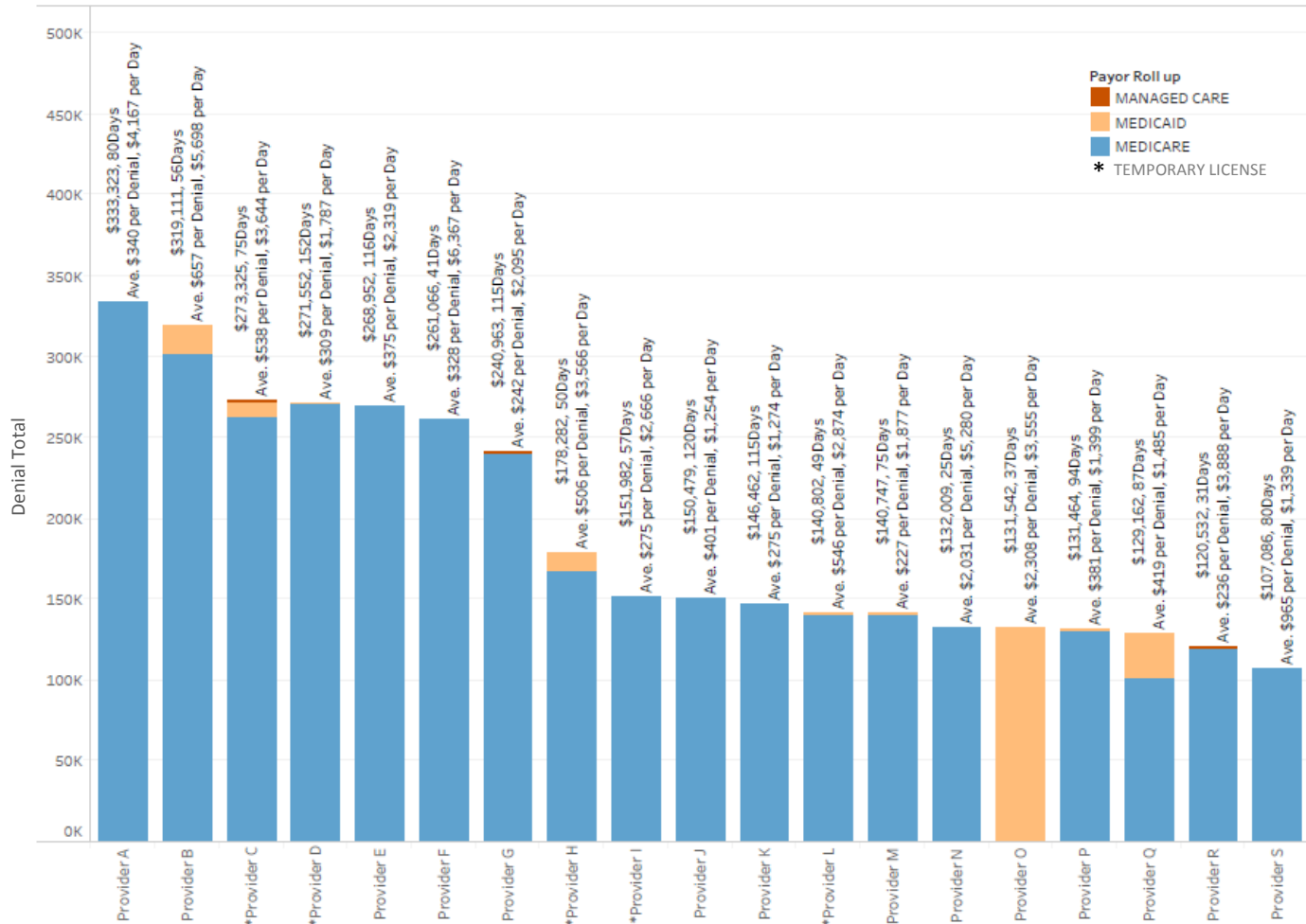
A Priority Finding is defined as “an issue identified by an internal audit that, if not addressed timely, could directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole.”

Appendix B

Average Charge per Denial and Day for Providers with \$100K in denials

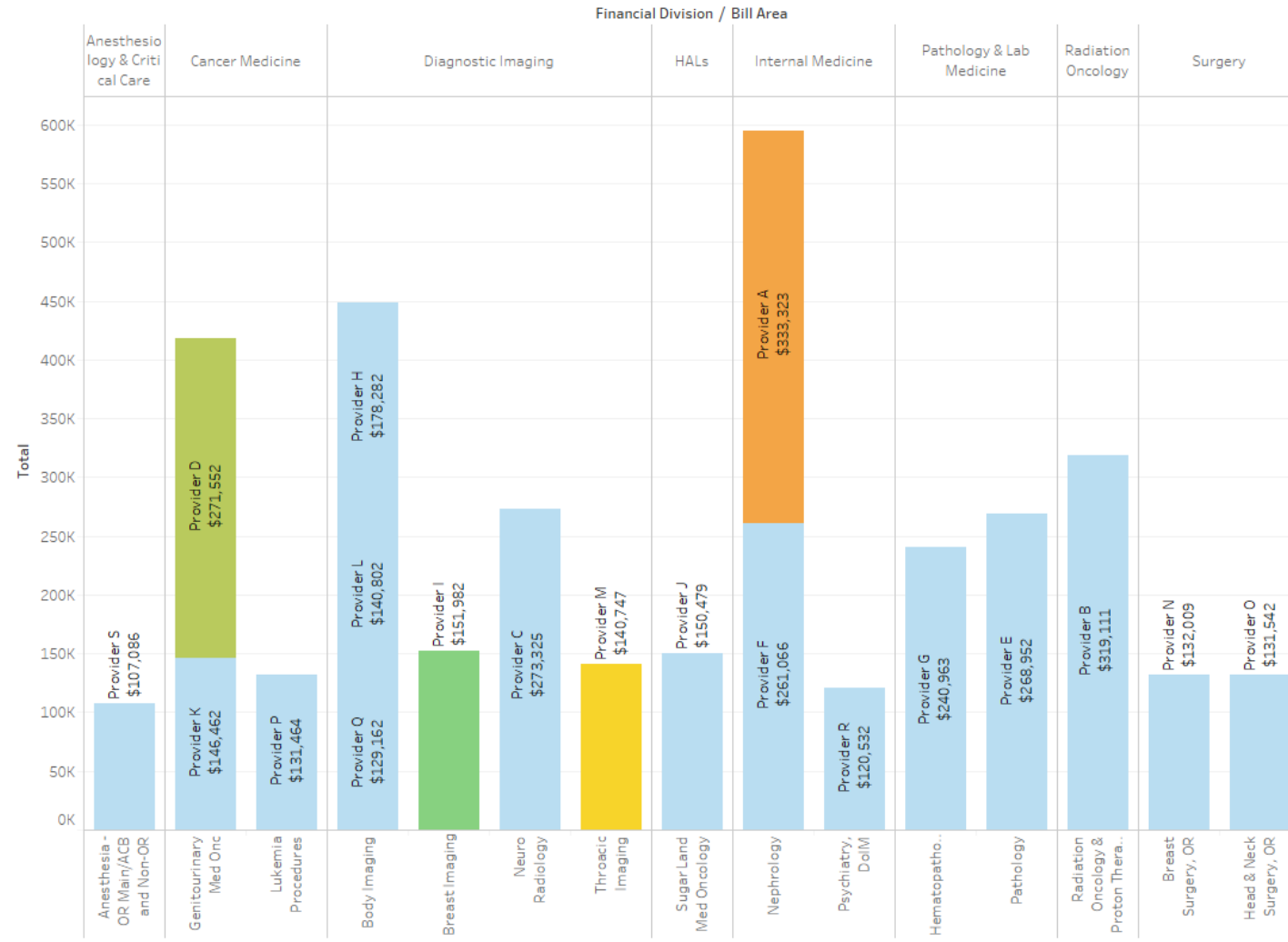
(limited to Denial B7-Provider not elig 4 pmt on date of svc)

9/1/2016 - 4/30/2018



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By Financial Division, Bill Area and Provider
 (Limited to Denial B7-Provider not elig 4 pmt on date of svc)
 9/1/2016 - 4/30/2018



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