OFFICE OF THE CITY AUDITOR
COLORADO SPRINGS, COLORADO

12-16 Memorial Physician Network Billing Cycle Audit Report

September 2012

Office Of The City Auditor
Colorado Springs, Colorado

12-16 Memorial Physician Network

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Purpose

The purpose of our audit was to review billing cycle processes in the Memorial Physician Network (MPN), to determine if additional controls were needed. We also reviewed whether MPN was in compliance with applicable policies and procedures.

Highlights

As a newer business segment of Memorial Health System, we conclude that MPN needed additional internal controls primarily in the areas of past due balance collection and insurance contract reimbursement review. These processes were not fully developed at the time of our review. We recognized MPN is a new, growing and complex business segment. MPN processes and systems were separate from Memorial Health System's established financial operations.

The MPN business segment had experienced significant growth and had been in existence for less than two years. During this start-up period, MPN personnel implemented a newly acquired software package and put in place polices and procedures to support business processes. Issues were encountered which may have presented challenges to system and process development. We noted significant improvements in billing and claim denial resolution processes during the period under review. However, the current billing system functionality did not allow automated review of insurance contract reimbursements. MPN expected to implement the contract reimbursement review process in August 2012. Collection procedures for past due balances were not fully in place or consistently followed.

The MPN business segment consisted of 15 physician clinics with 50-55 providers, and represented less than 5% of Memorial gross billings. The MPN

(Continued on page 2)

Management Response

Memorial was in agreement with most recommendations. See their responses included in the report.

Recommendations

1) Priority should be placed on development and implementation of a process which will ensure insurance payments are in accordance with contracts.
2) Initiate tracking and benchmarking, and develop goals for claim denials experience rates.
3) If feasible, given the pending lease, obtain a separate tax identification number for MPN. Consider assigning responsibility for cash posting activities to MHS to reduce coordination efforts.
4) Revise credit balance policy to specify how often balances are reviewed. Correct credit balances as necessary.
5) Review system accesses and make changes to improve segregation of duties. Ensure refunds are approved by someone other than the individual entering the refund request. Consider reducing the number of administrative access privileges and review employee transactions on employee accounts.

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12-16 Memorial Physician Network

September 2012

(Highlights continued from page 1)

Business Office staff of 18-20 was responsible for all aspects of billing, receipts and collections. MPN personnel indicated that integration, insurance contracting, and credentialing issues impacted system development.

Receipts as a percentage of gross billings was lower than management's target for the MPN business segment.

We performed a test of 145 randomly selected charges for patient visits, as well as other tests with results summarized below.

Billing and Denial Management

- Cycle times improved—first quarter 2012 denials were completed in 75% less time than in first quarter, 2011. Days required to generate a claim improved in this same period from 38 days to 10 days for accounts in our test.
- 17% of claims tested were resubmitted to payors.
- Insurance was not verified in 43% of visits tested.
- Approximately 800 open fee tickets over 30 days old were outstanding.
- At May 31, 2012, unresolved credit balances were $.53 million. A dedicated resource was assigned to review credit balances.

Collection Process

- Collection procedures were performed for approximately 45% of test accounts with past due balances.
- Electronic referral to collection agencies began in May 2012. At May 31, 2012, the balance in self-pay accounts over 120 days not referred to collection was $1.1 million.

Contract Revenue Verification

- Billing software did not have an automated process to verify compliance with payor contracts. This process was under development.

At the time of our review, an agreement was pending for the University of Colorado Health to potentially operate Memorial Health System, including the MPN business segment, under a long-term lease arrangement to begin October 1, 2012.

(Recommendations continued from page 1)

6) Clinic and Business Office personnel should work open fee tickets in a timely manner as specified by policies and procedures. Management should review more frequently for compliance.

7) Develop and implement methodical processes to perform in-house collection follow-up and refer older past due accounts to collection agencies.

8) Consider manual procedures and performance standards to ensure insurance is verified prior to initial claim filing. Track resubmitted claims rates and perform root cause analysis to determine if resubmitted rates can be reduced.

9) Management should develop and test a continuity plan to operate the business in the event of a natural disaster or smaller disruption.

10) Supervisors should ensure cash posting procedures are consistently followed to prevent reconciling items in the cash account.

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OFFICE OF THE CITY AUDITOR
PUBLIC REPORT

Date: September 28, 2012

To: President Hente, President Pro-Tem Martin, and Members of Council,
Memorial Health System Compliance and Audit Committee of the Board of Trustees

Re: 12-16 Memorial Physician Network (MPN) Audit

We conducted an audit of Memorial Physician Network (MPN) billing and collection process. The audit covered the period of January 1, 2011 through May 31, 2012. The purpose of our audit was to review MPN billing cycle processes to determine if additional internal controls were needed. We also reviewed to determine whether MPN was in compliance with applicable policies and procedures.

The MPN business segment had been in existence less than two years at the time of our review. During this start-up period, MPN added 15 clinics to the network, and implemented a newly acquired software package. We observed significant improvement in key processes during our audit period as MPN developed processes to support the billing cycle.

Although some follow-up on past due accounts was performed by MPN personnel, the follow up and collection process for past due balances was still under development and procedures were not consistently followed at the time of our review. The current billing system functionality did not allow automated review of reimbursements for compliance with insurance contracts. The expected date of implementation for the contract reimbursement review process was August 2012.

We conclude that MPN, as a newer business segment of Memorial Health System, needed additional internal controls primarily in the areas of past due balance collection and insurance contract reimbursement review. These processes were not fully developed at the time of our review. We recognized MPN is a new, growing and complex business segment. MPN processes and systems were separate from Memorial Health System's established financial operations.

During our audit, we identified ten observations and recommendations which are detailed in the attached report. Our audit work identified significant improvements in days to generate a claim and cycle time to resolve denials during the period we reviewed with ongoing improvements underway. More detail on these items can be found in the Commendable Practices section of our attached report.

As always, feel free to contact me if you have any questions.

Sincerely,

Denny Nester, MBA, CPA, CIA, CGFM, CFE, CGAP
City Auditor

Cc:
Mike Scialdone, Interim Chief Executive Officer, Memorial Health System
Tracy Narvet, Controller, Memorial Health System
Mary J. Yantis, Vice President of Business Office, Memorial Physician Network
John Wyckoff, Compliance Officer, Memorial Health System
Mary Kay Albertson, Director of Business Office, Memorial Physician Network

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Memorial Physician Network Billing Cycle Audit

Office of the City Auditor

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Memorial Physician Network Billing Cycle Audit

Office of the City Auditor

REPORT DETAILS

PURPOSE AND SCOPE

The purpose of our audit was to review billing cycle processes to determine if additional internal controls were needed. We also reviewed to determine whether Memorial Physician Network (MPN) was in compliance with applicable policies and procedures

The scope of our audit did not include compliance with Medicare or Medicaid laws and regulations. We did not review charge coding accuracy or reimbursement verification in our review.

The audit covered the period of January 1, 2011, through May 31, 2012. To accomplish our audit objectives we reviewed policies and procedures and obtained an understanding of the internal control structure for the medical claims management revenue cycle. Our methodology included an examination of the MPN records, reports and activities, interviews of management and staff, and compliance tests.

BACKGROUND

Memorial established the Memorial Physicians Network in September 2009, which was a new business segment, but not a separate legal entity of Memorial Health System. Financial activities for MPN were included in Memorial Financial Statements. MPN consisted of clinics that provided physician services to both inpatients and outpatients. Approximately 50-55 physicians were on staff during our review. In recent months, the number of patient visits to clinics was approximately 8,000-10,000 per month.

In the past two years, MPN Business Office staff had implemented a billing software system for physician practices that had not previously been used by the Health System. MPN staff, most of which were new to the Health System, initiated processes and procedures for the new business segment in this two-year period while adding 15 new clinics to the Network.

Implementation of a billing, collections, and payment software module began in April 2010. The Business Office Director and staff joined the organization beginning in July 2010, and in September 2010, MPN began generating bills for one clinic using the software. MPN Business Office personnel indicated that a number of issues were encountered during system development. These included integration issues, and issues related to insurance contracts and credentialing processes supporting the business segment. These factors may have had significant impacts on system development and operations, but were not examined in this review.

MPN's Business Office function was responsible for all aspects of the billing, payment posting, and collection process for the physician services and had a staff of approximately 18-20. MPN physicians, Business Office staff, and clinical staff were employees of MPN and MHS. MPN processed billings for all clinics as well as one clinic not owned by MPN and MHS. This business process had not previously been reviewed by the Office of the City Auditor.

The MPN staff at clinic locations was responsible for coding and generating fee tickets for services provided and collecting copayments. In addition to managing the billing process, Business Office personnel were responsible for verifying insurance, making payment arrangements with patients owing balances, following up on insurance denials, along with follow up and collection of past due insurance

and self-pay balances. Payment remittances were posted to the MPN billing system by MPN personnel. Refunds, bad debt write-off and adjustments were also processed by the MPN Business Office. Additionally, the Business Office performed the coordination with the billing software vendor, administered system access, and was responsible for necessary training and system implementation for new clinics added to the MPN network.

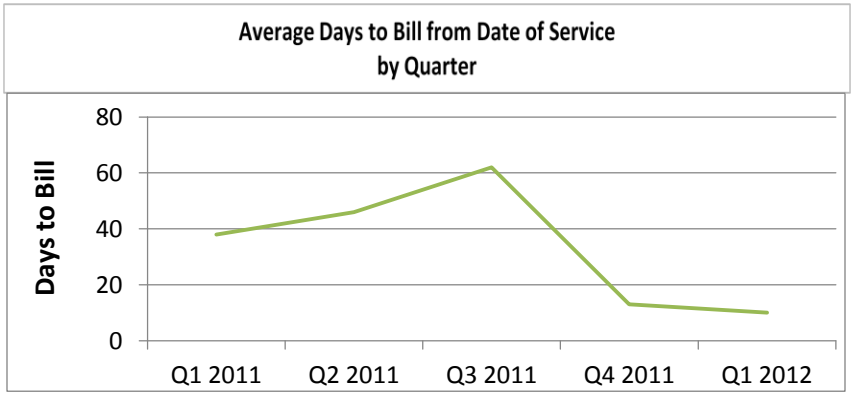
At the time of our review, an agreement was pending for the University of Colorado Health (UCH) to potentially operate Memorial Health System, including the MPN business segment, under a long-term lease arrangement to begin October 1, 2012.

COMMENDABLE PRACTICES

We noted that the MPN business segment had been in existence for less than two years at the completion of our review. MPN personnel developed systems and processes to accomplish all aspects of billing, receipts, and collection in a relatively short period of time. We observed significant improvement in timeliness and accuracy of key processes related to the billing cycle during the period under review. During system and process development, 15 clinics were added to the network. MPN demonstrated a strong commitment to development of policies and procedures to support the billing cycle during our review.

Additionally, it was noted that MPN made significant improvements in cycle time required to resolve insurance denials during the period under review. Denials in the first quarter of 2012 for accounts in our test were completed in 75% less time than in the first quarter of 2011, from approximately 200 to 50 days to investigate and resolve.

A similar improvement was noted in the number of days required to generate a claim, as follows:



CONCLUSION

We conclude that MPN, as a newer business segment of Memorial Health System, needed additional internal controls primarily in the areas of past due balance collection and insurance contract reimbursement review. These processes were not fully developed at the time of our review. We recognized MPN is a new, growing and complex business segment. MPN processes and systems were separate from Memorial Health System's established financial operations.

During our audit, we identified ten audit observations and recommendations which are detailed in the following pages.

OBSERVATIONS, RECOMMENDATIONS AND RESPONSES

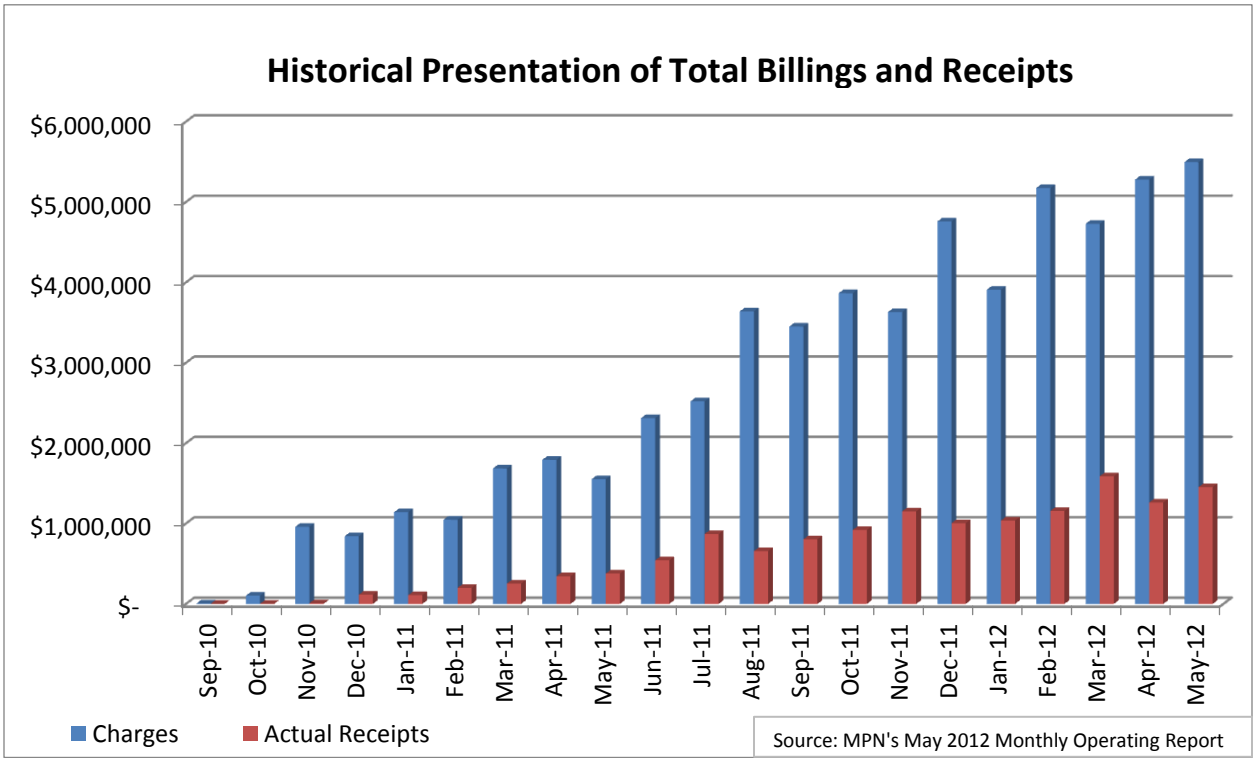
OBSERVATION 1 – MPN DID NOT HAVE A PROCESS TO ENSURE CONTRACTUAL ADJUSTMENTS WERE IN COMPLIANCE WITH INSURANCE CONTRACTS

Based upon Explanation of Benefit (EOB) Statements, MPN posted contractual adjustments for each claim. Any balance other than contractual adjustment that was not paid by primary insurance was posted to secondary insurance, patient responsibility, or insurance balance. Outstanding insurance balances were reported on the monthly insurance recovery report. Insurance balances could result from insurer claim edits. MPN's policy required management to review the insurance recovery report for large or unusual items for follow up after 120 days.

However, MPN's billing system did not have the ability to calculate an expected reimbursement for each claim at the beginning of the process which would facilitate follow up of significant differences between expected and actual reimbursement. Because the MPN billing system did not allow for automated analysis of contract reimbursement rates, MPN was in the process of developing manual procedures for assessing contract reimbursement rates. MPN management estimated that procedure development was approximately 60% complete at the end of our review. Management indicated they expected to implement variance review procedures in August, 2012.

After our fieldwork was completed, but prior to the issuance of this report, MPN indicated they performed a review of claims payments to date to identify incorrect reimbursements, and negotiations were in progress for incorrect insurance reimbursements that were identified. As MPN completed this analysis after our audit fieldwork was complete, we did not review or test MPN's process to identify potential adjustments for completeness or accuracy.

MPN had a goal in place that overall receipts should be a percentage of gross charges. However, because the variance review of payments as compared to contractual rates was not in place, we could not determine with certainty the reason that receipts have been lower than management's objective. Receipts compared to gross billings to date were as follows:



AUDITOR'S RECOMMENDATION

We recommend MPN place priority on development and implementation of a process that ensures timely review of both contractual adjustments and amounts related to insurer edits within a reasonable tolerance. In addition, continued efforts should be made to pursue adjustment of any past claims where significant potential incorrect reimbursements may exist.

MEMORIAL'S RESPONSE

We agree with the recommendation. MPN will have a manual process to review the accuracy of contractual reimbursements by August 31, 2012. The process will include the identification and resolution of any and all inaccurate reimbursements received from contracted insurance payers.

The pursuit of appropriate payments of past outstanding claims is already in process. Meetings have already been held with various insurers and claims not paid due to contracting issues have already been resolved.

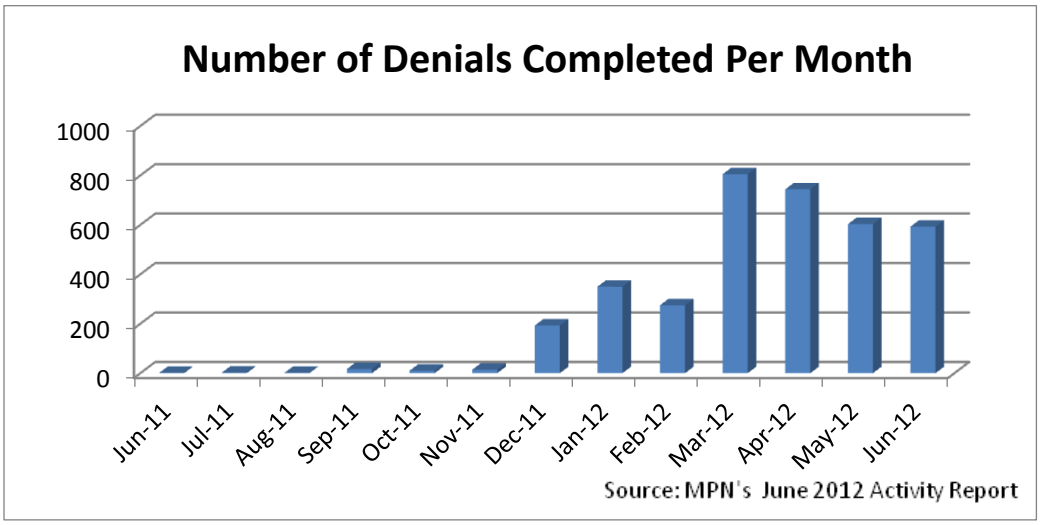
OBSERVATION 2 –CLAIM DENIALS WERE NOT INVESTIGATED AND RESOLVED TIMELY PRIOR TO APRIL 2012

Claims were defined as denied if they have been submitted to the insurance payor, then reported as not payable by service code for a specific reason. In second quarter 2012, we reviewed MPN's process for follow up of claim denials. Prior to February 2012, claim denials were not being worked on a consistent basis. As of the end of April 2012, the time required to follow up on claim denials improved and denials were worked on a daily basis in accordance with policy. Denial reports were retained and follow up was appropriately logged to ensure all denials were worked.

Claims volume increased in late 2011, as certain software issues were resolved, which generated a greater volume of denials to be addressed. The number of providers increased from 2 providers in September 2010, to 57 providers in May of 2012, which also increased the number of denials to be addressed.

MPN tracked reason codes for denials worked by clinic and provider. These clinics were contacted when trends such as increased number or types of claims denials were identified by the Business Office. However, we noted as the billing system did not provide accurate transaction counts, overall denial rates as compared to total claims were not available for tracking or reporting. As a result, we were unable to benchmark MPN's denial rate experience against industry standards.

MPN's activity summary reports for the period June 2011 through May 2012 indicated MPN resolved the following number of denied claims each month related to coding errors:



AUDITOR'S RECOMMENDATION

MPN should continue to work denials daily to ensure revenues are collected for services billed.

MPN should put in place a tracking mechanism and goals for denial experience rates by clinic practice type. Additionally, efforts should be made to accurately calculate denial experience rates using available data.

MEMORIAL'S RESPONSE

We agree with the recommendation. The transition to the new electronic medical record and billing system should provide a more automated process of tracking denials allowing us to determine accurate denial rates. In the interim, MPN manually maintains an excel spreadsheet identifying denials for each provider, by each clinic, dollar amount denied versus dollar amounts appealed. This information will be used as an educational opportunity during clinic Monthly Operating Reports starting 9/1/12 and is currently used as educational information during physician audits.

OBSERVATION 3 – MPN AND MEMORIAL SHARED A TAX IDENTIFICATION NUMBER WHICH RESULTED IN A COMPLEX POSTING PROCESS

MPN and Memorial shared the same tax identification number, which was used by insurance companies to remit claims payments. In instances where insurance companies combined MPN and Memorial payments, the amount due was separated and transferred to the other entity using a clearing account. This added complexity to the cash payment posting process, increased the time and effort needed to post payments, and caused possible delays in payment posting to patient accounts.

Time spent transferring funds between MPN and Memorial and reconciling these transfers would be reduced if separate tax identification numbers were used for Memorial and MPN. However, given the potential pending lease with UCH, it may not be practical for MPN to pursue obtaining a separate tax identification number at the present time.

If Memorial posted all payments for MPN, this would require Memorial employees be granted access to the MPN billing system. Additionally, MPN posted payments to individual service charges, while Memorial posted the payment to the claim in total. If Memorial posted payments on behalf of MPN, appropriate training and testing would be necessary to ensure payment posting accuracy.

AUDITOR'S RECOMMENDATION

Consideration should be given to separate tax identification numbers for MPN and Memorial if considered practical given lease arrangements.

Additionally, consideration should be given to assigning responsibility for all cash posting activities to Memorial to reduce coordination efforts.

MEMORIAL'S RESPONSE

We agree with the recommendation. All of the above recommendations were reviewed and considered at the time of system implementation. The separate TAX ID number was discussed with the Colorado Springs City Attorney. All of these options were deemed inappropriate at that time. With the advent of the new electronic medical record and billing system and the possible long term lease agreement with UHC this issue should be resolved. In the interim we will continue to operate as is.

OBSERVATION 4 – UNRESOLVED CREDIT BALANCES EXISTED

We noted significant unresolved credit balances. Although no industry benchmarks were identified, MPN management had set 2% as a reasonable target. We noted as of May 31, 2012, credit balances were $.53 million or approximately 4.9% of the $10.8 million accounts receivable balance. Prior to the issuance of this report, MPN had a policy in place to promptly review credit balances related to government payors.

We reviewed a sample of 20 credit balances as of June 19, 2012. Approximately 40% were identified as potential duplicate payments or other potential refunds. The remaining credit balances were posting errors. MPN management indicated they estimated about half of the outstanding credit balances were errors rather than outstanding refunds.

The policy in place stated credit balances related to non-government payors should be reviewed on a "regular" basis, but did not indicate how often credit balances were to be reviewed. We understand that MPN assigned a dedicated resource to review and resolve credit balances on a daily basis during our audit fieldwork.

AUDITOR'S RECOMMENDATION

MPN should revise the credit balance review policy to specify how often credit balances are to be reviewed. Priority should be given to correcting errors identified during credit balance review.

MEMORIAL'S RESPONSE

We agree with the recommendation. MPN has updated the policy to read that credits are reviewed on a daily basis (currently 1 Full Time Equivalent Employee works these accounts). We are reviewing and correcting the duplicate postings created by the software posting templates (which have been corrected). The new electronic medical record and billing system will have a more stable posting function.

OBSERVATION 5 – SYSTEM SECURITY AND REPORTING OF TRANSACTIONS TO EMPLOYEE ACCOUNTS WERE NOT ADEQUATE

We noted that Business Office Supervisors had access rights to perform most transactions in the billing system. This access was a segregation of duties concern as a potential existed for one person to enter and approve refunds. The Business Office Director reviewed the refund check listing, which helped to mitigate risk of unauthorized refunds. However, the effectiveness of this control was reduced as the Business Office Director could enter and approve refund transactions.

Additionally, some of these MPN Business Office Supervisors had administrative access in the billing system that would allow changes to access profiles. Because administrator access can effectively allow an individual to make changes both to the profiles and process unauthorized transactions, administrative access should be limited to as few employees as possible. When possible, those with administrative access should not process transactions on a daily basis.

Although MPN had the ability to generate reports of transactions to employee accounts, a policy and procedure was not in place to routinely review employee transactions or to prevent an employee from making changes to his or her account.

AUDITOR'S RECOMMENDATION

Access rights should be restricted to limit the ability of employees to both enter and approve refunds. The Business Office Director should not perform refund transactions.

MPN should review the administrative access privileges and consider reducing the number of employees with this access or implement mitigating controls to prevent or detect unauthorized transactions.

A security protocol should be put in place to prevent employees from processing transactions to their own accounts. Alternatively, reports of all transactions made by employees to their own accounts should be generated on a defined schedule and reviewed by management. Documentation of this review should be retained.

MEMORIAL'S RESPONSE

We agree with the recommendation. The MPN Business Office Director does not perform refund transactions. All security and access concerns are addressed with the transition to the new electronic medical record and billing system. In the interim, MPN will work with the billing system software vendor to determine the best method for preventing the access of an employee's own account. This will be completed by the first quarter 2013.

OBSERVATION 6 –OPEN FEE TICKETS FOR CHARGE ENTRY WERE NOT CONSISTENTLY RESOLVED IN THE TIME ALLOWED BY POLICY

Open fee tickets were created by the billing software when patients visited a provider per the clinic schedule, but had not been billed for services provided. The open fee ticket report was a key control in reconciling scheduled appointments to charge entry and minimizes lost revenue by flagging unbilled visits.

Per MPN's policies and procedures, each clinic was responsible for resolving their open fee tickets on a weekly basis. Additionally, the MPN Business Office was to review all clinic open fee tickets monthly to ensure they were in compliance.

We noted several clinics had open fee tickets that were unresolved from service dates in the fourth quarter 2010, when MPN began billing the first clinics. It was noted not all open fee tickets will result in additional billings, but unresolved open fee tickets for billable charges can result in a loss of revenue.

We selected 48 open fee tickets from the May 1, 2012, open fee ticket report that had dates of service from February 1 to April 23, 2012. We asked that MPN management review these open tickets. Management determined some of the fee tickets were still open and unresolved. Ten of the open fee tickets were subsequently billed to a responsible party for a total amount of $2,800. At the time of our review, MPN had a total of 818 open fee tickets over 30 days old; 544 of these open fee tickets were from 2011 and 2010.

MPN management indicated many of the items on the open fee ticket report are not billable. However, the possibility of unbilled revenue exists if all items on the report are not resolved timely.

AUDITOR'S RECOMMENDATION

MPN should ensure open fee tickets are reviewed by the clinics weekly and by the Business Office monthly as required by policy to ensure all billable charges are identified and billed.

MEMORIAL'S RESPONSE

We agree with the recommendation. This policy has been reviewed with all clinic managers and business office personnel. The system report is reviewed monthly by the clinic liaison for compliance with the policy.

OBSERVATION 7 – MPN HAD NOT FULLY DEVELOPED COLLECTION PROCESSES AND ACCOUNTS RECEIVABLE AGING BALANCES EXCEEDED MANAGEMENT'S TARGET

MPN was not effectively and timely following up with past due accounts in accordance with their established policies and procedures. On accounts where the patient (rather than an insurance payor) was responsible for the balance, procedures stated a phone call to the responsible party should be made after 30 days. Subsequently, a telephone call and letter should be sent at 60 days, a pre-collection letter sent after 90 days and after 120 days the account should be referred to an outside agency for collections. For accounts with balances due from an insurance payor, follow up was to be performed per policy after balances were outstanding for 120 days.

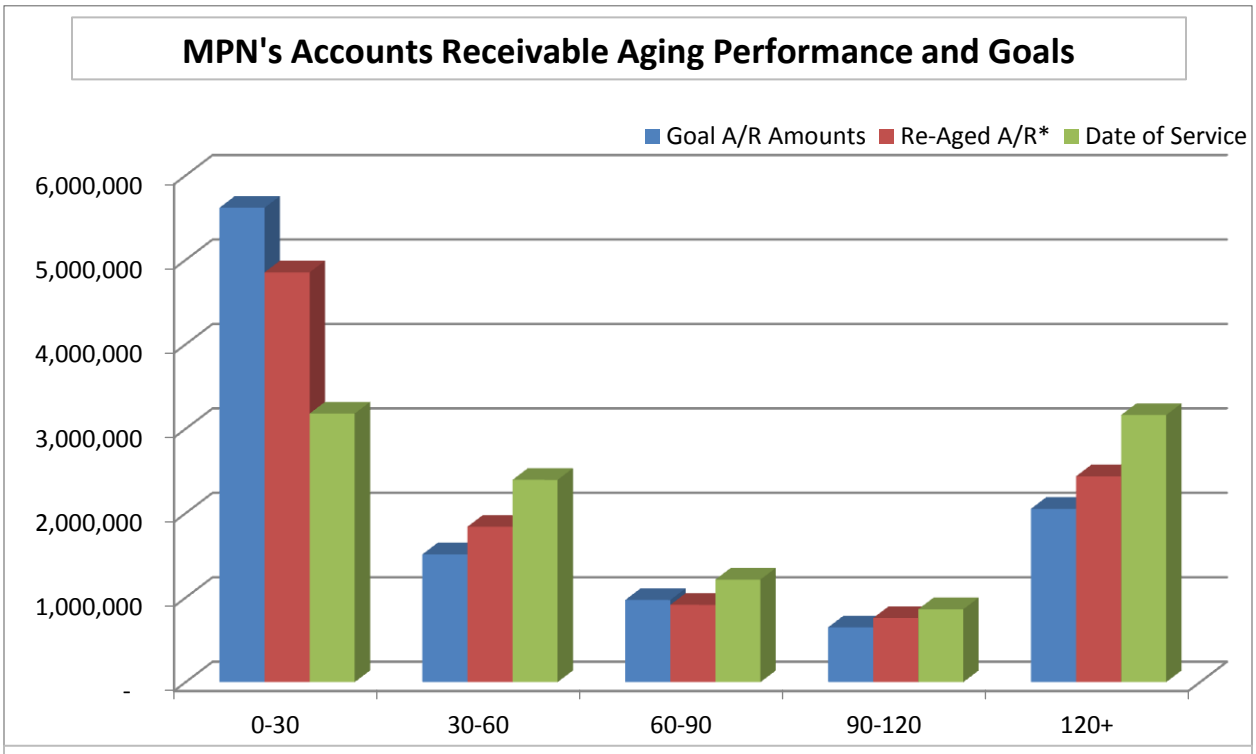
As of May 31, 2012, the balance in self-pay accounts over 120 days not referred for collection was $1.1 million. We noted there was no policy in place outlining the timing and procedures for referring self-pay accounts to an outside agency for collection. For the period under review, accounts were not routinely referred to a collection agency.

During our fieldwork, MPN developed and began implementing a process for electronic referrals to collection agencies. During May and June 2012, accounts with a balance of approximately $28,000 were referred to outside collection agencies for past due balances. MPN planned a phased implementation by clinic for electronic referrals to collection agencies.

We selected a sample of 145 patient visits to review collection activities for compliance with policy. Our test accounts were selected by sampling accounts outstanding over 120 days with balances over $20,000 as well as a random sample of 112 additional accounts. If the billing system records indicated some follow up or collection activity had been performed, we considered the collection requirements to have been followed. If no collection activity was indicated in the billing system, we noted non-compliance with collection procedures. We found collection processes were in place for approximately 45% of past due accounts tested.

Collections Statistics	Count	% of Sample Population		
Accounts not past due	85	58.6%		
Past due collection path followed	27	17.9%	27	45.0%
Past due collection path not followed	33	26.2%	33	55.0%
Total	145	100.0%	60	100.0%

As accounts were not routinely referred to collection, and collection procedures were not consistently applied, aging balances exceeded management's targets, as follows:



*Re-aging generally indicates that when a new bill for the service is issued (e.g. the responsible party changes, the balance is re-aged based upon the date of the new bill.)
**Indicate gross billings prior to contractual adjustments

MPN tracked re-aged* accounts receivable balances as compared to an internal goal for balances in the various aging categories. MPN's goal for percent of balances in the over 120 days category was 19%. The actual percentage in the re-aged over 120 days category was 23%. MPN also provided comparison benchmark data from the Medical Group Management Association (MGMA) industry association for multi-specialty hospital-owned practices (included above).

Additionally, we noted that MPN monthly operating reports indicate that MPN had a goal of 50 days worth of billings in accounts receivable. However, at May 31, 2012, per MPN's monthly operating reports, the balance in accounts receivable was approximately 63 days.

We noted clinic personnel collect co-payments from patients but otherwise do not receive payments on patient accounts. Instead, patients are asked to contact the Business Office to make payments on patient balances other than co-payments. As clinic personnel have in-person contact with patients, the necessary system changes should be made to allow clinic personnel to accept payments.

AUDITOR'S RECOMMENDATION

MPN should fully develop and implement methodical processes to perform in-house collection follow-up to minimize lost revenues.

Performance standards should be put in place to help ensure timely collection activities are performed.

Manual procedures should be considered to expedite referral to outside collection agencies to accelerate recovery of past due amounts.

We recommend MPN make the necessary system changes to allow clinic office staff to receive payments on accounts other than co-payments.

MEMORIAL'S RESPONSE

We agree with the recommendation. MPN now has a manager of the business office whose responsibilities include monitoring of compliance with the MPN policies and procedures including those relating to in-house collections and follow-up. All employees have reviewed and signed an acknowledgement of the MPN policies.

We implemented referral of accounts to outside collections May 2012 and have developed a timeline for having all clinics implemented by October 1, 2012.

Processes for payments to be received by clinic staff are currently being developed and will be in place by the end of third quarter.

OBSERVATION 8 –CLAIMS TESTS INDICATED RE-SUBMITTAL RATES WERE SIGNIFICANT AND INSURANCE WAS NOT CONSISTENTLY VERIFIED

We tested 145 accounts for compliance with collection policies and procedures. For these test accounts, we noted that 15 claims (10%) in our test sample required correction prior to submission to insurance. Additionally, 24 claims (17%) were submitted to the payor, and then required re-submittal to the payor to correct errors. The total percentage of claims that required correction of the original charge before or after filing with the payor was 27%.

Error correction and re-submittal of claims resulted in additional days between the date of service and the corresponding receipt, which could increase past due balances. Additionally, there was an additional cost incurred to process corrected claims.

We also noted in our test of 145 accounts that insurance was not verified in 43% of accounts tested. We understand insurance verification was an automated process which is dependent on software interfaces with insurance payors and timely update of insurance eligibility data. MPN indicated that resource constraints would not allow staff to make calls to verify insurance when eligibility could not be confirmed electronically. However, when insurance eligibility was not validated, this increased the possibility that bill corrections would be needed and receipt of payment could be delayed.

AUDITOR'S RECOMMENDATION

MPN should consider whether manual procedures and performance standards should be in place to ensure insurance is verified prior to initial claim filing.

MPN should track internal error corrections and rates for re-submittal of claims to insurance payors, and perform root cause analysis to determine if error rates and re-submittal rates can be reduced.

MEMORIAL'S RESPONSE

We disagree with the recommendation. We currently use electronic insurance verification which is the industry standard. Manual process of this function would be labor intensive and an expensive endeavor. The industry continues to make progress in this area; both insurance and providers are committed to a better system.

MPN believes that an accurate calculation of the resubmission rate is difficult at best with the current software requiring the use of two separate modules for claim filing. This appears as if a claim has been submitted more than once.

CITY AUDITOR'S RESPONSE

Our recommendation is that management consider whether manual procedures should be implemented. Based on Memorial's Response, we respect their decision and note that they are accepting the risk associated with not implementing additional processes. We concur that the calculation of resubmission rates was difficult. Therefore, we were conservative in reporting only those re-submittal instances within our sample that were verified.

OBSERVATION 9 – THE MPN BUSINESS OFFICE DID NOT IMPLEMENT A BUSINESS CONTINUITY PLAN IN THE EVENT OF LONG-TERM LOSS OF RESOURCES

Business continuity planning is a comprehensive approach to operate the business with minimum interruptions after a natural disaster or in the event of smaller disruptions including illness or departure of key personnel. The MPN Business Office plan addressed aspects of information systems business continuity. However, the plan did not address other aspects of business continuity such as employee systems access or alternative work locations in the event the MPN Business Office resources were inaccessible due to internal or external events.

The lack of planned procedures to access offsite resources during long-term disruption events may result in the inability to restore operations in a timely manner.

AUDITOR'S RECOMMENDATION

We recommend that the MPN Business Office review with Memorial's Information Systems Department the steps required to continue the MPN's operations during long-term loss of facilities, key personnel and the billing processing system. If possible, MPN's Business Office should complete an impact study outlining estimated costs should the billing, payment, and collection process become inaccessible for long durations. A continuity plan should be developed and tested.

MEMORIAL'S RESPONSE

We agree with the recommendation. A formal plan will be documented by September 2012. Currently key business office personnel have the ability to relocate at several locations. Key personnel have been cross trained on operations. Loss of access to the billing system is identified in downtime policies located at each clinic and in the MHS Information System policies.

OBSERVATION 10 – MPN DID NOT CONSISTENTLY FOLLOW CASH POSTING PROCEDURES WHICH CREATED RECONCILING ITEMS IN THE CASH ACCOUNT

We noted payments were not always posted to a clearing account by MPN personnel in accordance with procedures during our audit period. This resulted in reconciling items in the cash bank account and significant additional time spent by Memorial Accounting personnel completing bank reconciliations. This was brought to the attention of MPN management during our audit, and MPN employees began posting payments in accordance with policy and procedures. We understand a procedure was put in place to require regular supervisor review of cash posting process to ensure accuracy.

AUDITOR'S RECOMMENDATION

MPN should ensure supervisors monitor and review the cash posting process to ensure it is accurate.

MEMORIAL'S RESPONSE

We agree with the recommendation. It was discovered during the audit process that the payment posting process was not being consistently followed by one employee. This was immediately corrected and the manager routinely reviews this process. Reporting of the activity in the clearing accounts is reported and verified on a daily basis.

City Council's Office Of The City Auditor

Colorado Springs, Colorado

About our Office

The mission of the Office of the City Auditor is to provide City Council with an independent, objective and comprehensive auditing program for operations of the City. Our auditing program includes:

- Evaluating the adequacy of financial controls, records and operations
- Evaluating the effectiveness and efficiency of organizational operations
- Providing Council, management and employees objective analysis, appraisals, and recommendations for improving systems and activities

The Office of the City Auditor is responsible for auditing the systems used by the City of Colorado Springs and its enterprises, including Colorado Springs Utilities and Memorial Health System. We perform a variety of audits for these entities, including financial audits, performance audits, contract audits, construction audits, and information system audits. We also perform follow-up on a periodic basis to monitor and ensure management actions have been effectively implemented.

Authorization and Organizational Placement

Our audits are conducted under the authority of Chapter 1, Article 2, Part 7 of the Colorado Springs City Code, and more specifically parts 703, 705 and 706 of the Code. The Office of the City Auditor is structured in a manner to provide organizational independence from the entities it audits. This independence is accomplished by the City Auditor being appointed by and reporting directly to the City Council.

Audit Standards

The audit was conducted in a manner that meets or exceeds the International Standards for the Professional Practice of Internal Auditing, a part of the Professional Practices Framework promulgated by the Institute of Internal Auditors, with the exception of the requirements under standards 1312 and 1321 to obtain an external quality assurance review once every five years. We do not believe this non-compliance impacted the quality of our audit.

The audit will include interviews with appropriate personnel and such tests of records and other supporting documentation as deemed necessary in the circumstances. We will review the internal control structure and compliance tests . Sufficient competent evidential matter was gathered to support our conclusions.

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