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STATE OF LOUISIANA
LEGISLATIVE AUDITOR

E. A. Conway Medical Center
Louisiana Health Care Authority
State of Louisiana
Monroe, Louisiana

May 7, 1997

Financial and Compliance Audit Division

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Legislative Auditor

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E. A. CONWAY MEDICAL CENTER
LOUISIANA HEALTH CARE AUTHORITY
STATE OF LOUISIANA

Monroe, Louisiana

Management Letter
Dated April 10, 1997

May 7, 1997

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April 10, 1997

E. A. CONWAY MEDICAL CENTER
LOUISIANA HEALTH CARE AUTHORITY
STATE OF LOUISIANA
Monroe, Louisiana

As part of our audit of the State of Louisiana's financial statements for the year ending June 30, 1997, we conducted certain procedures at E. A. Conway Medical Center, Louisiana Health Care Authority. Our procedures included (1) a review of the medical center's internal control structure; (2) tests of financial transactions for the years ending June 30, 1997, and June 30, 1996; (3) tests of adherence to applicable laws, regulations, policies, and procedures governing financial activities for the years ending June 30, 1997, and June 30, 1996; and (4) a review of compliance with prior year report recommendations.

The Annual Fiscal Reports of E. A. Conway Medical Center, Louisiana Health Care Authority, are not within the scope of our work, and, accordingly, we offer no form of assurance on those reports. The medical center's accounts are an integral part of the State of Louisiana's annual financial statements, upon which the Louisiana Legislative Auditor expresses an opinion.

Our procedures included interviews with management personnel and selected medical center personnel. We also evaluated selected documents, files, reports, systems, procedures, and policies as we considered necessary. After analyzing the data, we developed recommendations for improvements. We then discussed our findings and recommendations with appropriate management personnel before submitting this written report.

In our prior management letter dated October 12, 1995, we reported a finding relating to untimely billing for medical services. That finding has not been resolved by management and is included in this report.

Based upon the application of the procedures referred to previously, all significant findings are included in this report for management's consideration.

Untimely Billing for Medical Services

For the third consecutive audit, E. A. Conway Medical Center did not ensure that bills were issued timely to inpatients or their guarantors after discharge. The Louisiana Health Care Authority (LHCA) Procedure Manual for Accounts Receivable requires the medical center to submit a bill to the patient/guarantor 10 days following the date of service or discharge. LHCA suspended the 10-day rule for 180 days effective July 1, 1996; however, to date, a current accounts receivable patient bill policy has not been implemented by LHCA.

Of a sample of 20 inpatients for whom billings had not been issued within 10 days after discharge, 17 patients, with charges totaling $70,070, had not been billed within a reasonable time after discharge. Delays ranged from 12 to 160 days beyond established time limits and were attributable to a variety of reasons, including incomplete documentation of diagnosis, medical records were either not available or could not be located, and the Medical Records Section was behind in coding.

In a report dated January 5, 1997, which was obtained from the medical center, 840 discharged patients were listed as not being billed within 10 days of discharge; the billable value of these patient charges totaled $4,547,592. The delays in billings result in the loss of time value of the billings and increase the risk that the charges will not be collected.

The medical center management should take aggressive action to review its current procedures for its patient billings to ensure that discharged patients receive bills timely. In a letter dated February 20, 1997, Mr. Roy D. Bostick, Director, stated the hospital is currently requiring overtime, hiring additional personnel in the Medical Record department, stationing additional personnel on the patient care floors to obtain discharge information from the physician, and requiring patient charts to be coded and abstracted before discharge analysis and before the charts are allowed to be checked out of the Medical Record department. In addition, specific responsibilities will be assigned so patient accounts can be reviewed on a daily basis to acknowledge delays and/or problems.

Failure to Comply With State Bid Law

E. A. Conway Medical Center did not have written documentation to support the basis of an emergency when making an emergency purchase and did not obtain written or facsimile quotes from vendors when making purchases valued between $2,000 and $5,000, as required by Louisiana law. Louisiana Revised Statute 39:1598 requires the

Chief Procurement Officer to make a written determination providing detailed information concerning the basis of the emergency, as well as the basis used for contractor (vendor) selection. Executive Order No. MJF 96-14 requires that facsimile or written solicitations be sent to at least five bona fide, qualified bidders for purchases between $2,000 and $5,000.

Our test of 16 purchasing transactions revealed that for all 16 transactions, only telephone quotes, not written or facsimile quotes, were obtained before issuing purchase orders for items valued between $2,000 and $5,000. Of the 16 purchasing transactions, 2 were for emergency purchases, and there was no documentation to support the claim that the purchase was a true emergency. Departmental management did not submit purchase requisitions for items to the purchasing department in sufficient time to allow for obtaining written or facsimile solicitations. Failure to obtain written or facsimile quotes from vendors increases the risk that purchase awards could be made inappropriately and errors not be detected. In addition, the medical center may not receive the most competitive prices for the purchase, or the purchase may not be made at the lowest possible cost.

Departmental management should closely monitor supplies and anticipate the need for often used items and submit purchase requisitions to the purchasing department timely. The medical center's purchasing department should strictly adhere to the procedures mandated by law for purchases deemed true emergencies and for purchases between $2,000 and $5,000. In a letter dated February 20, 1997, Mr. Roy D. Bostick, Director, stated the problem will be corrected by having all requisitions that fall within the $2,000 to $5,000 range be received and reviewed by the purchasing agents to ensure five written/faxed bids have been obtained and that all appropriate documentation is satisfied to meet the intent of the law.

Incompatible Functions and Failure to Update System Security

E. A. Conway Medical Center does not have adequate internal control procedures over access to the Advanced Governmental Purchasing System (AGPS) and the Governmental Financial System (GFS). A good internal control structure provides for adequate segregation of duties as well as timely updates of personnel changes so that system access can be properly restricted. In our test of access controls, we identified the following weaknesses:

1. Two employees in the purchasing department had incompatible duties in that they could enter new vendors, purchase requisitions, purchase orders, receiving reports, and vendor invoices into the AGPS.

2. One employee in the accounting department had incompatible duties in that the individual could enter new vendors, purchase requisitions, and purchase orders into the AGPS.

3. The medical center's security administrator had data entry and document approval capability in AGPS and GFS in addition to her security access.

4. Four employees were transferred between departments without timely updates being made to their AGPS and/or GFS access. Changes in access did not occur until 6 days to 11 months after the transfers.

5. For five of seven terminated employees, access to the systems was not discontinued until one week to eight months after their termination dates.

Systems security was compromised because the medical center's security administrator assigned incompatible functions to certain users, and the user departments did not timely notify the security administrator of employee transfers or terminations. Inadequate segregation of duties and failure to timely update systems access increases the risk that errors or irregularities could occur and not be detected in a timely manner and that unauthorized information could be entered and processed in these systems.

The medical center should ensure that a proper segregation of duties is maintained for those individuals having access to AGPS and GFS and that the security administrator is restricted from having enter and approval capability. The medical center should also implement procedures that would provide prompt notification to the security administrator when an employee terminates or transfers. In a letter dated February 20, 1997, Mr. Roy D. Bostick, Director, stated that the Human Resource department will provide a list of personnel actions on a weekly basis, but prior to the effective date of such personnel actions. The list from Human Resources will provide the employee name, department, and effective date of the personnel action to allow timely update of the system. In addition, steps are currently underway to remove inappropriate function capabilities and will review the security administrator position to ensure that this person does not have input capabilities.

Patient Billing Control Weaknesses

E. A. Conway Medical Center does not have a proper segregation of duties within the patient billing function and does not follow the LHCA policy of transferring patient accounts to collection agencies. An adequate internal control structure should provide for the segregation of duties so that one person would not be placed in a position both to initiate and conceal errors or irregularities in the normal course of their duties. In addition, LHCA policy requires that patient accounts outstanding over 120 days be transferred to collection agencies. Our review of the patient billing functions disclosed the following weaknesses:

1. There is a lack of segregation of duties in that the supervisor for the Patient Accounts Section is also the supervisor for the Admitting and Screening Section.

2. Incompatible duties exist in that employees in the Patient Accounts Section who receive payments on patient accounts can also change patients' financial classes and make adjustments to patient accounts. In addition, the supervisor for Patient Accounts does not review system reports relating to changes to patient accounts to verify the correctness of changes made by employees in Patient Accounts.

3. The medical center has not sent all outstanding patient accounts over 120 days to collection agencies.

According to management, these conditions occurred because the current supervisor for Patient Accounts was temporarily placed in charge of the Admitting and Screening Section when the previous supervisor for that section resigned; employees of the Patient Accounts Section allowed incompatible duties because there are not enough employees to adequately segregate duties; and because of increased workload, the Patient Accounts Section has not taken the time to follow up accounts 120 days old to determine appropriate action.

Failure to adequately segregate duties in the Admitting and Screening and Patient Accounts sections could result in unauthorized changes to patient accounts, misappropriation of collections, and inappropriate bad debt write-offs. Also, failure to follow established guidelines for transfer of patient accounts to collection agencies could result in lost revenues.

The medical center should segregate the supervisory functions over Patient Accounts and Admitting and Screening, and the supervisor for Patient Accounts should timely obtain, review, and certify the necessary reports relating to changes to patient accounts. The medical center should also ensure that all patient accounts in excess of 120 days are sent to collection agencies as required by LHCA policy. In a letter dated February 20, 1997, Mr. Roy D. Bostick, Director, stated that a process will be implemented in the Patient Accounts department to review the Aged Trial Balance report to determine why accounts in excess of 120 days are still on the report and have not been transferred to collections. In addition, recruitment efforts to fill the Admit/Screening department supervisor are currently being implemented, which will provide separate front-line supervisors for both the Patient Accounts and Patient Screening departments.

Inadequate Controls Over Patient Screening

E. A. Conway Medical Center does not have adequate controls over its patient screening process. The purpose of the screening process, as defined in the Patient Admitting and Screening Policy and Procedures Manual, is to determine the existence of third party insurance and/or the financial ability of the patient to pay for the services received at the medical center. The medical center assigns a financial class code based on the patient's public support, income verification (documentation supporting the patients latest known income), and household size. This financial code determines the appropriate type of patient billing. Good business practices dictate that financial class codes be assigned based on accurate data to ensure recovery of all revenues to which the medical center is entitled. However, the policy of LHCA, the oversight body, does not require verification of income and household size for all free care applicants. Verification of this information is necessary to ensure the accuracy of the financial class code assigned.

Our examination of the screening process disclosed the following deficiencies:

1. Out-patient re-screening policy was not followed for 14 out of 67 applicable patients receiving treatment (21 percent).

2. In-patient income verification for 11 of 20 patients (55 percent) was not sufficiently documented.

These deficiencies occurred because some out-patients needing re-screening were treated in the clinics either by arriving just in time for their appointments or clerks did not notice the re-screening notice on the patient appointment schedule, thus allowing patients to be seen by the doctor without re-screening. Also, LHCA policy does not

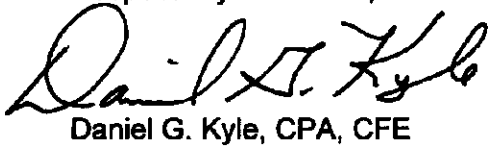
place sufficient emphasis on the need for complete and accurate data in the screening process. Incorrect financial class codes could result in inaccurate patient billings and lost revenue to the state.

The medical center should strengthen its existing controls for re-screening out-patients and should work with the LHCA to establish policies that require the verification of public support, income, and household size for all applicants for free care. In a letter dated February 20, 1997, Mr. Roy D. Bostick, Director, stated that efforts are underway to set up a central registration desk whereby all patients will be registered, indexed, if necessary, and screened or re-screened, if applicable. Management stated that patients will not be allowed to report for clinic appointments unless they have been processed through central registration. Management also stated that during the screening process, documentation will be required to include drivers' license, social security card, income tax return, and household size. This information will be documented to verify the Financial Class Code for patients.

The recommendations in this report represent, in our judgment, those most likely to bring about beneficial improvements to the operations of the medical center. The varying nature of the recommendations, their implementation costs, and their potential impact on operations of the medical center should be considered in reaching decisions on courses of action. The findings relating to the medical center's compliance with laws and regulations should be addressed immediately by management.

This report is intended for the information and use of the board and its management. By provisions of state law, this report is a public document, and it has been distributed to appropriate public officials.

Respectfully submitted,



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