UT SOUTHWESTERN
MEDICAL CENTER

Robert Rubel, CPA, CIA, CISA
Director

Office of Internal Audit

November 1, 2010

John Keel, CPA
Office of the State Auditor
206 East Ninth Street, Suite 1900
Austin, TX 78701

Dear Mr. Keel:

We have prepared this report on the activities of The University of Texas Southwestern Medical Center at Dallas' Office of Internal Audit in compliance with the requirements established in the Texas Internal Auditing Act (Texas Government Code, Section 2102). This report provides information on our FY 2010 and 2011 audit plans, audits completed and recommendations. Our audit work for FY 2010 focused on key externally requested and Institutional risk based areas- patient care, research, information technology, compliance, core business processes, and other areas based on risk.

Our recommendations will help enhance the effectiveness of Medical Center operations by improving internal controls such as the reliability and integrity of financial information, safeguarding of assets, compliance with applicable policies and procedures, economical and efficient use of resources, and accomplishment of goals and objectives.

We appreciate the opportunity to participate in this process. For further information about the contents of this report and/or to request copies of audit reports, please contact me at 214-648-6106.

Sincerely,

Robert Rubel

cc: Michael Sparks, Governor's Office of Budget and Planning
Ed Osner, Legislative Budget Board
Internal Audit Coordinator, State Auditor's Office
Ken Levine, Sunset Advisory Commission

5323 Harry Hines Blvd. / Dallas, Texas 75390-9017 / 214-648-6106 Fax 214-648-6145
www.utsouthwestern.edu

The University of Texas Southwestern Medical Center at Dallas Internal Audit Annual Report for Fiscal Year 2010

November 1, 2010

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER AT DALLAS

INTERNAL AUDIT ANNUAL REPORT FOR FISCAL YEAR 2010

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I. Audit Plan for Fiscal Year 2010

FY 2010 Audit Plan Audit/Project	Hours
Financial Audits	
UT System Requested/Externally Required Audits	
FY2009 Financial Statement Audit - Financial	600
FY2009 Financial Statement Audit - IT	400
FY2009 Financial Statement Audit - Fraud	100
FY2010 Financial Statement Audit (Interim)	400
FY2010 Financial Statement Audit IT (Interim)	200
Presidential Housing, Travel and Entertainment Expenses	150
Time & Effort Reporting/American Recovery and Reinvestment Act (ARRA)	400
National Pediatric Infectious Disease Foundation AFR	100
Carryforward Audits	100
Financial Audits Subtotal	**2450**
Operational Audits	
Risk Based Tier One Audits	
MSRDP Billing Operations	600
MSRDP Charge Entry	500
University Hospitals – Procurement and Contract Monitoring	600
Construction Project Management	400
Risk Based Tier Two Audits	
University Hospitals – Simmons Comprehensive Cancer Center	500
Governance: Policies & Procedures	350
Emergency Preparedness (non-priority)	400
Change in Management Audits	
Grants Management	150
Other	300
Carryforward Audits	200
Operational Audits Subtotal	**4000**

Compliance Audits	
UT System Requested/Externally Required Audits	
FY09 SAO A-133 Federal Audit Assistance	50
FY09 SAO Statewide Financial Audit Assistance	200
UTS 155: Policies and Procedures Regarding Practice Plan Operations – MSRDP	300
UTS 155: Policies and Procedures Regarding Practice Plan Operations – FSP School of Health Professions	200
Family Practice Residency Program Grants (THECB requirement)	150
Graduate Medical Education Grant (THEBC requirement)	200
Ethics-related objectives, programs and activities – IIA Standards 2110.A2	250
Risk Based Tier One Audits	
University Hospitals – Quality Indicators	400
Risk Based Tier Two Audits	
Physician Billing Compliance	400
Clinical Trials Billing	300
Carryforward Audits	100
Compliance Audits Subtotal	**2550**
Information Technology Audits	
UT System Requested/Externally Required Audits	
Information Technology Governance Audit – IIA Standards 2110.A2	250
IT Exchange Program	100
Risk Based Tier One Audits	
Risk Based Tier Two Audits	
EPIC Resolute Implementation	600
PeopleSoft Implementation	800
University Hospitals – Sunquest MiSys Lab System Implementation	500
Carryforward Audits	100
Information Technology Subtotal	**2350**

Follow-up Audits	**600**
Projects	
Audit Projects	
UT System Requests	200
Special Requests - Audits	500
Consulting Projects	
Fraud Prevention and Analysis	500
Special Requests - Consulting	1000
Other Projects	
Requests for Information/Assistance	200
Internal Audit Annual Report	60
Quality Assurance Review	300
Annual Audit Plan and Risk Assessment	300
Training Provided by IA	150
Internal Audit Committee	400
Internal Projects	400
Reserve for other Special Requests/Investigations	1000
Projects Total	**5010**
Total Budgeted Hours	**16960**

Explanation of Deviations from Fiscal Year 2010 Audit Plan

As documented in the Audit Committee meeting minutes, the following items contributed to the deviations from the FY 2010 Audit Plan.

- Financial Audits - All priority audits were completed for this section. Presidential Travel and Entertainment Expenses was completed by the University of Texas System Audit Office.
- Operational Audits - *UT System Requested/Externally Required Audits* – no audits scheduled.
- Operational Audits - *Risk Based Tier One Audits* – All priority audits were completed for this section.
- Operational Audits - *Risk Based Tier Two Audits* - All priority audits were completed for this section including Emergency Preparedness which was a non-priority audit.
- Operational Audits - *Change in Management Audits* - All priority audits were completed for this section.
- Compliance Audits - *UT System Requested/Externally Required Audits* –All priority audits were completed for this section.
- Compliance Audits - *Risk Based Tier One* - All priority audits were completed for this section.
- Compliance Audits - *Risk Based Tier Two* - Due to management turnover and implementation of EpicResolute, Clinical Trials Billing was moved to the FY 2011 audit plan. All other priority audits were completed for this section.

- Information Technology Audits - *UT System Requested/Externally Required Audits-* All priority audits were completed for this section. IT Exchange Program was a consultative project with the University of Texas at Dallas. No report was issued for this project.
- Information Technology Audits - *Risk Based Tier One* – No audits for this section.
- Information Technology Audits - *Risk Based Tier Two* - All priority audits were completed for this section. PeopleSoft Implementation was a consultative project with Medical Center management. No report was issued for this project.
- Follow-up Audits - All planned follow-up audits were completed.
- Projects - All planned projects were completed.

II. List of Audits Completed

10:01 FY 2009 Financial Statement Audit

Report Number	10:01	Report Date	12.01.09	Name of Report	FY 2009 Financial Statement Audit
High Level Audit Objective	UT System requested				
Observations Findings Recommendations	**1. Compliance with the Monitoring Requirement defined in *UTS 142.1- Policy for the Annual Financial Report ("UTS 142.1"), Section 2.3 "Monitoring Plan" [Carry-forward from 2008 AFR Recommendations. See recommendation #1 on Appendix A]*** To ensure the accuracy, completeness, and integrity of the institutional Annual Financial Reports and the UT System's Consolidated Annual Financial Report, the Financial Reporting Officers should ensure that the institution develops and implements a comprehensive monitoring plan in compliance with UTS 142.1. Additionally, the Financial Reporting Officers should perform inspections throughout the year and report the results of the inspections to the Audit Committee and Controller's Office quarterly. Consistent with UTS 142.1, institutional Internal Audit Offices will verify annually whether the monitoring plans are in place and functioning as intended.	Current Status	Incomplete/Ongoing The department has developed a comprehensive monitoring plan, but has yet to report on its resulting activities.	Fiscal or Other Impact	Non-compliance with UTS 142.1 Section 2.3 Monitoring Plan could result in incomplete or inaccurate department account reconciliation or inadequate segregation of duties over transactions.

10:01 FY 2009 Financial Statement Audit, continued

Observations Findings Recommendations	**2. EPIC Resolute Change Management** The Epic Resolute team should ensure that HSIR 2010 is updated to reflect current change management processes including but not limited to the following: a. The Epic Resolute team should ensure that HSIR 2010 defines change management request types (such as service request, Change request, etc.) and the documentation requirements for each type of change. b. The Epic Resolute team should ensure that HSIR 2010 identifies how and where employees and management are to store required change management documents. c. The Epic Resolute team should conduct periodic quality assurance reviews by testing a sample of changes for documentation completeness.	Current Status	Fully Implemented	Fiscal or Other Impact	Incomplete revision of policy and procedures results in inconsistent practices and potential internal control gaps.

10:02 FY10 Financial Statement Audit (Information Technology)

Report Number	10:02	Report Date	12.01.09	Name of Report	FY 2009 Financial Statement Audit
High Level Audit Objective	See Results documented above in 10:01 Financial Statement Audit				
Observations Findings Recommendations		Current Status		Fiscal or Other Impact	

10:04 American Recovery and Reinvestment Act ("ARRA") Compliance

Report Number	10:04	Report Date	08.19.10	Name of Report	American Recovery and Reinvestment Act ("ARRA") Compliance
High Level Audit Objective	Externally required				
Observations Findings Recommendations	To enhance compliance with state ARRA guidance, we recommend adding the following clause to all ARRA funded contracts: *Each recipient or sub-recipient awarded funds made available under the ARRA shall promptly notify the Office of Internal Audit for the University of Texas Southwestern Medical Center of any credible evidence found by the recipient or regulatory agency that a principal, employee, agent contractor, sub-contract, or other person(s) associated with the contract has submitted a false claim under the False Claims Act or has committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct involving those funds. The Office of Internal Audit can be reached at 214-648-6106 or http://www.utsouthwestern.edu/fraud/hotline.*	Current Status	Fully implemented	Fiscal or Other Impact	Prompt communication of credible evidence for false claims ensures UTSW is aware of and educated on such conditions related to federal ARRA funds. A lack of timely communication increase potential for non-compliance activities to continue unheeded and increase UTSW's exposure to significant penalty. The False Claims Act imposes severe penalties on a contractor who (among other things) makes a false statement in association with a payment request or any other type of claim for payment on a project. A contractor who violates the False Claims Act is potentially liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per violation.

10:05 National Pediatric Infectious Disease Foundation FY 2009 AFR

Report Number	10:05	Report Date	02.22.10	Name of Report	National Pediatric Disease Foundation
High Level Audit Objective	The Office of Internal Audit performed the NPIDF engagement to assist in fulfilling the objectives of providing and reporting accurate and reliable financial and operating information. The following audit objectives were deemed necessary to provide this assistance: 1. Financial statements review • Determine if the financial statements are materially accurate, reliable, and supported by financial records of the NPIDF • Review financial transactions of NPIDF for proper support 2. Assist in the NPIDF financial report consolidation into the AFR as required by GASB Statement 14 • Provide reconciliation and supporting documentation requested by the Fiscal Reports to consolidate the NPIDF financial report into the Medical Center's AFR 3. Assist NPIDF Management to complete the necessary forms to satisfy filing requirements of the Internal Revenue Service for Exempt Organizations • Draft and monitor the completion of the Form 990 and supplemental schedules for NPIDF tax filing due January 15, 2010				
Observations Findings Recommendations	Based on the procedures performed, the financial statements for NPIDF were deemed materially accurate. NPIDF financial information has been properly included in the consolidated financial results of the Medical Center and has been properly reported on the Form 990 within the required timeline.	Current Status	No Recommendations	Fiscal or Other Impact	

10:06 MSRDP Billing Operations

<table>
<tr><th>Report Number</th><th>10:06</th><th>Report Date</th><th>09.15.10</th><th>Name of Report</th><th colspan="2">MSRDP Billing Operations</th></tr>
<tr><td>High Level Audit Objective</td><td colspan="6">The primary objective of this audit was to provide reasonable assurance that there are adequate and effective controls for MSRDP Billing Operations to ensure the following:
• Safeguarding of assets
o Cash controls and handling procedures are adequate
• Compliance with laws, regulations, and contracts
o Policies/procedures/workflows are updated to reflect the newly implemented EPIC Resolute system
• Effectiveness and efficiency of operations
o Claims and denials are worked effectively and efficiently to decrease loss of revenue
o Work queues are effectively managed to ensure cash flow and accurate processing of claims
o Patient reimbursements are made timely</td></tr>
<tr><td>Observations Findings Recommendations</td><td colspan="3">1. Check Validation Machines
a. We recommend that Global Payments invoices be reviewed to ensure that MSRDP is not paying for check validation machines at clinics that have been closed. Clinic Managers should be reminded of the requirements regarding the use of check validation machines and instructed to educate their staff in the proper usage of the machines.</td><td>Current Status</td><td>Incomplete/Ongoing

Education of staff is ongoing.</td><td>Fiscal or Other Impact: Failure to use check validation machines prevents the timely identification of fraudulent checks or checks with insufficient funds, which could lead to loss of revenue or excessive bank fees. Also, keeping the checks on hand for the daily deposit could lead to unauthorized parties obtaining patient checking account numbers.</td></tr>
</table>

10:06 MSRDP Billing Operations, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	b. We recommend that the Aston Clinics consider using electronic check conversion machines. This would eliminate the need to retain physical checks for the daily deposit, as a merchant summary for the check conversion machine can be run each day. It would also significantly reduce or eliminate the incidence of Not Sufficient Funds checks. Aston Business Services could enforce the usage of these machines by refusing to accept physical checks in their daily deposits.		Incomplete/Ongoing Implementation of electronic check conversion machines is in process.		This would eliminate the need to retain physical checks for the daily deposit, as a merchant summary for the check conversion machine can be run each day. It would also significantly reduce or eliminate the incidence of NSF checks.
	2. Epic Resolute Reports We conducted interviews with the Physician Collection Team Managers to determine how their workflows and reporting activities have been affected by the implementation of Epic Resolute in June 2009. We identified that Epic Resolute reports and/or training on reports may need enhancement to help support claim follow-up. A recommendation to conduct a reports training/needs assessment was issued in the 10:07 MSRDP Charge Entry report.		Substantially Implemented Training on EPIC Resolute reports ongoing.		Ensures complete and accurate charge capture and claim resolution.

10:07 MSRDP Charge Entry

Report Number	10:07	Report Date	09.15.10	Name of Report	MSRDP Charge Entry
High Level Audit Objective	Internal Audit (IA) performed the engagement to provide reasonable assurance that there are adequate and effective controls for MSRDP charge entry. The following audit objectives were identified: • Accomplishment of established goals and objectives – Perform analytical review procedures to select departments for testing of key charge entry controls • Effectiveness and efficiency of operations – Review and evaluate the charge entry and reconciliation processes • Reliability and integrity of financial and operational information – Obtain statistical sample of charges and determine whether charges are entered correctly into the information system and reconciled • Compliance with laws, regulations, and contracts – Test that CPT codes marked on patient encounter forms or medical records match entries posted in the information system • Follow-up on prior audit recommendations – Determine if appropriate corrective action has been taken to address prior audit recommendations.				
Observations Findings Recommendations	1. **Outdated Clinical Operations Ambulatory Services Policies** We recommend that the policies within the Ambulatory Services Policy Manual and SOP Handbook be reviewed and updated to account for implementation of Epic Resolute. This review would also be an opportunity to begin the process of aligning Ambulatory Policies and the University Hospital policies. The guidance contained within the UT System Administration policy INT 155 Formulation and Adoption of Policies by UT System Administration should be reviewed to promote consistency.	Current Status	Incomplete/Ongoing The Assoc. VP for Physician and Clinical Affairs along with the Assistant VP of Ambulatory Affairs are working to update the Services Manual with a target date of 3/1/2011.	Fiscal or Other Impact	Up to date policies and procedures allow for current practices and systems to be used appropriately and less opportunity to deviate from those established processes.

10:07 MSRDP Charge Entry, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	2. Absence of Ambulatory Services Clinical Operations Charge Entry Reconciliation Policy and Procedure The Associate Vice President for Physician and Clinic Financial Affairs and Assistant Vice President of Ambulatory Operations will draft an Ambulatory Services Clinical Charge Operations Charge Reconciliation Policy. The draft policy will be submitted to the Revenue Cycle Committee for approval. The Revenue Cycle Workgroup (RCWG) will be charged with developing an Ambulatory Services Clinical Operations Charge Entry Reconciliation procedure. The procedure will include a list of Epic Resolute reports and Resolute functions that will be utilized in the charge entry reconciliation procedure. The RCWG membership consists of the Chair, Department Billing, IR and MSRDP staff (including the Associate Vice President for Physician and Clinic Financial Affairs). The membership will be increased to include Assistant Vice President of Ambulatory Operations and clinic management/supervisory staff. The Ambulatory Services Clinical Operations Charge Entry Reconciliation Policy will be completed by the 1st of March 2011.		Incomplete/Ongoing The Assoc. VP for Physician and Clinical Affairs along with the Assistant VP of Ambulatory Affairs are working to update reconciliation process with a target date of 3/1/2011		Absence of a Charge Entry reconciliation policy could result in inconsistent, or cessation, of important internal control practices increasing the potential for charge entry errors, loss of revenue, and non-compliance with laws and regulations.

10:07 MSRDP Charge Entry, continued

Observations Findings Recommendations	3. **Epic Resolute Reports** We recommend that a report needs assessment be conducted to determine if the issues identified during the audit are due to a lack of reports required to support charge capture and claim resolution and/or a lack of training. The assessment should include a determination of the need for staff education on the types of reports available and training on the use of reports for charge capture and claim resolution. Therefore, the assessment should include a discovery phase and gap assessment to identify information needs from all applicable areas and the process for how reports will be requested, developed, cataloged/organized, and communicated.	Current Status	Incomplete/Ongoing The Assoc. VP for Physician and Clinical Affairs along with the Assistant VP of Ambulatory Affairs are developing a needs assessment for reporting with a target date of 3/1/2011	Fiscal or Other Impact	Ensures complete and accurate charge capture and claim resolution. Inadequate information for managing operations increases the risk for errors and omissions in the billing process to go undetected.

10:08 University Hospitals Procurement and Warehousing

Report Number	10:08	Report Date	08.02.10	Name of Report	University Hospitals Procurement and Warehousing
High Level Audit Objective	The primary objective of this audit is to review controls and processes over hospital purchasing and warehousing.				
Observations Findings Recommendations	1. **UH St. Paul Bulk Warehouse access controls need improvement** Materials Management should review the access and security for the UH St. Paul bulk inventory and implement physical controls to prevent access to inventory by non-inventory employees.	Current Status	Fully Implemented	Fiscal or Other Impact	Uncontrolled access to medical center inventory increases the risks for potential misappropriations of inventory and opportunity costs to the Medical Center.

10:08 University Hospitals Procurement and Warehousing, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	2. Absence of a Physician Preference purchasing procedure UH Purchasing should: a. Create a written procedure to ensure Physician Preference purchases are periodically monitored for compliance with the legislation b. Consider gaining a legal opinion to identify appropriate circumstances for using the following purchasing statutes: § Texas Government Code, §2155.1441 *Health Care Purchasing*, Texas Education Code §51.9335 *Acquisition of Goods and Services*, and Texas Government Code §2155.067 *Proprietary Purchases* (Sole Source). c. Provide the Value Analysis Committee information on Physician Preference purchases to ensure those meet managements' intent and goals.		Fully Implemented Substantially Implemented UH Director of Materials Management to obtain legal opinion by target date of 10/31/10. Substantially Implemented. Committee to be provided information regarding physician preference items by target date of 10/31/10.		Monitoring procedures of statutory requirements ensures assists to ensure compliance with related regulations.

10:09 Construction Project Management

<table>
<tr><td>Report Number</td><td>10:09</td><td>Report Date</td><td>09.23.10</td><td>Name of Report</td><td colspan="2">Construction Project Management</td></tr>
<tr><td>High Level Audit Objective</td><td colspan="6">The primary objective of this audit is to provide the President and Board of Regents with reasonable assurance that policies and procedures used by Design and Construction to manage construction and renovation projects under $4 million has adequate and effective controls to ensure:
• Reliability and integrity of financial and operational information
• Safeguarding of assets
• Compliance with laws, regulations, and contracts,
• Accomplishment of established goals and objectives; and
• Effectiveness and efficiency of operations</td></tr>
<tr><td>Observations Findings Recommendations</td><td colspan="3">1. Ensure Medical Center and State bidding requirements are met for construction purchases between $5,000 and $25,000.
Bids should be solicited from companies expected to be able to fulfill the bid specifications. Bid specifications should be written to indicate the features of a product rather than to indicate a certain brand name and model number specific only to a sole vendor, unless the phase "or equal" is used. If only one vendor carries an item with the required features, a "sole source/proprietary purchase" justification should be written to "explain the need for the specifications and state the reason competing products are not satisfactory."

The bid solicitor should ensure that two HUB vendors are included in bid requests between $5,000 and $25,000. When two HUB vendors are not available, supporting documentation should be included in the file to support unavailability.</td><td>Current Status</td><td>Fully Implemented</td><td>Fiscal or Other Impact: Compliance provides assurance that contractors are fairly selected by an open bid process.</td></tr>
</table>

10:09 Construction Project Management, continued

Observations Findings Recommendations					
	2. Formalize established procedures to prevent inadvertent payment on final pay applications without review and approval by Physical Plant Accounting Physical Plant should document and formalize its informal procedures requiring Physical Plant Accounting to review and approve all payment requests and supporting documentation prior to payment. Physical Plant should communicate the written procedures to the Office of Accounting to ensure they understand the written process. We further recommend the development of a pay application processing checklist to be used by both Physical Plant and the Office of Accounting to ensure accurate payment procedures.	**Current Status**	Fully Implemented	**Fiscal or Other Impact**	Formalized process ensures Lien waivers are used by the Medical Center for absolution of any liability for non-payment of funds owed by the general contractor to the sub-contractors.
	3. Improve Process for Disencumbering of Excess Funds For projects with funds not disencumbered past 120 days of the date of substantial completion, management should document within related project files, explanatory notes as to cause of the delay. Management should be explicit within these notes as to the actions they have pursued to resolve further delay in the disencumbering of funds.	**Current Status**	Fully Implemented	**Fiscal or Other Impact**	The effect of delays in disencumbering excess funds from completed projects is that department clients are deprived of timely access to funds from their budgets.

10:10 University Hospitals Simmons Comprehensive Cancer Center

<table>
<tr><td>Report Number</td><td>10:10</td><td>Report Date</td><td>09.21.10</td><td>Name of Report</td><td colspan="3">University Hospitals Simmons Comprehensive Cancer Center</td></tr>
<tr><td>High Level Audit Objective</td><td colspan="7">The primary audit objective was to provide reasonable assurance that there are adequate and effective controls in the Cancer Center subsequent to the conversion on June 1, 2009 to ensure the following:
• Effectiveness and efficiency of operations (Objective A)
• Reliability and integrity of financial and operational information (Objective B)
• Safeguarding of assets (Objective C)
• Compliance with laws, regulations and contracts (Objective D)</td></tr>
<tr><td>Observations Findings Recommendations</td><td colspan="3">1. Policies & Procedures
Based on our procedures related to the clinical revenue-cycle operations, management should update or document policies and procedures to reflect current operating activity compliant with the applicable MSRDP and Hospital operating directives. Documented policies and procedures will allow for improved operational efficiency and transactional consistency in the daily activity consistent with management expectations. Additionally, the policies and procedures will define the controls in place to address the operational risks identified by management (i.e. approvals, reviews, monitoring).
We recommend the following:
• The development of a policy suite to serve as a complete and accessible repository of all active policies and procedures for the conical revenue-cycle of the Cancer Center. The policies and procedures should be organized to cover all significant operating activities.</td><td>Current Status</td><td>Incomplete/Ongoing

Cancer Center Billing Manager will develop a policy suite for all relevant policies and procedures related to billing at the Cancer Center with a full completion date of 9/1/2011.</td><td>Fiscal or Other Impact</td><td>Documented policies and procedure allow for improved operational efficiency and transactional consistency that meet management expectations and comply with related university, state, federal, etc. rules and regulations.</td></tr>
</table>

10:10 University Hospitals Simmons Comprehensive Cancer Center, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	• Finalized individual policies and procedures should include proper documentation as to effective date, management approval and documentation of a responsible party for monitoring and periodic review for consistency with the actual operating environment. • Once finalized, policies and procedures should be communicated to employees and readily available for future reference. The method of communication should be documented and include employee acknowledgement of receipt and understanding.				

10:10 University Hospitals Simmons Comprehensive Cancer Center, continued

Observations Findings Recommendations	Observations / Findings / Recommendations	Current Status	Status Detail	Fiscal or Other Impact	Impact Detail
Observations Findings Recommendations	**2. Collection of Patient Fees at Time of Service** Based on our findings in Billing and Collections, the Cancer Center should be collecting the portion of the hospital and physician fees which are the responsibility of the patient at the time of service. Collecting the proper fees at time of service improves cash flow, minimizes patient confusion with subsequent billing, improves collectability and complies with MSRDP and Hospital policies. We recommend the following: • Management develop and execute an action plan to identify and implement a method to determine the proper amount of fees to be collected from the patient at the time of service for both physician and hospital fees. • Once determined, the proper methodology should be incorporated into the applicable policies and procedures as discussed in Recommendation #1.	Current Status	Incomplete/Ongoing The Billing Manager will develop an action plan to identify and implement appropriate fees to be collected at time of serve for both physician and hospital. Due date is June 1, 2011.	Fiscal or Other Impact	Collecting the proper fees at time of service improves cash flow, minimizes patient confusion with subsequent billing, improves collectability and complies with MSRDP and Hospital policies.

10:10 University Hospitals Simmons Comprehensive Cancer Center, continued

Observations Findings Recommendations					
	3. Cash Handling Based on our findings in Billing and Collections, the Cancer Center should create and assign responsibility for a hospital fee change fund to avoid potential commingling of the collected fees and document separate procedures and controls necessary to ensure the safekeeping of the cash from receipt through deposit in accordance with the requirements of MSRDP and Hospital.	**Current Status**	Fully implemented.	**Fiscal or Other Impact**	Ensures accurate and complete collection of fees.
	4. Hospital Fees-Charge Capture Based on our procedures related to Charge Capture, we recommend Cancer Center management review current operating procedures and personnel involved in the manual charge capture of hospital fees and implement procedures to ensure improved controls including a secondary review and documentation requirements related to reconciliation and review procedures. Additionally, consideration should be given to implement necessary cross-training of personnel to perform important functions in the absence of an employee. Policies and procedures should be documented to incorporate the controls in place.	**Current Status**	Fully Implemented	**Fiscal or Other Impact**	Increase internal controls for manual driven processes.

10:10 University Hospitals Simmons Comprehensive Cancer Center, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	5. Financial Counseling Responsibilities Based on our procedures related to Financial Counseling, we noted the responsibilities of the financial counselor do not allow for a proper segregation of duties and include cash handling procedures. We recommend Cancer Center management review current operating procedures and personnel to determine that proper controls are in place to ensure the safe guarding of cash and proper monitoring and review of activities in this function.		Incomplete/Ongoing The Billing Manager is currently reviewing operating procedures to determine that proper controls are in place. Due date for this activity 2/1/11.		Segregation of duties related to cash increase control.
	6. Pharmacy Operations – Monitoring of Inventory Activity Based on our procedures, we recommend the following to improve the inventory control environment: • Until an appropriate inventory system is identified to address the 07:26 recommendation, the Top 23 Analysis should be performed on a timely basis and distributed to the appropriate Cancer Center management and the Hospital Pharmacy Director for review and approval. • The Top 23 Analysis should be brought current as soon as possible and a timeline for completion and distribution for a final review and approval by Cancer Center and Hospital Pharmacy Management should be defined and implemented.		Substantially Implemented Inventory processes are in the process of being documented and performed by a third party. Variance tolerances are in the process of being noted. Due date 10/31/10.		Physical controls and accountability reduce the risk of: • Undetected theft or loss • Unexpected shortages of critical items • Unnecessary purchases of items already on hand

10:10 University Hospitals Simmons Comprehensive Cancer Center, continued

Observations Findings Recommendations					
	• The procedures for preparing and performing the Top 23 Analysis should be documented and included in the inventory processes and include details related to the preparation, analysis, distribution and review of the report. Additionally, the variance tolerance should be noted to define those deemed significant and requiring additional investigation. • A third-party should perform quarterly physical drug inventories.	Current Status		Fiscal or Other Impact	
	7. **Pharmacy Operations-Documented Policies and Procedures** We recommend that policies and procedures related to inventory be documented and finalized to reflect the current operating environment.	Current Status	Substantially Implemented In the process of finalizing policies and procedures related to inventory. Due date 10/31/10.	Fiscal or Other Impact	Physical inventory controls improve visibility and accountability over inventory, which help improve storage and control excess or obsolete items.

10:11 Governance: Policies and Procedures

Report Number	10:11	Report Date	03.08.10	Name of Report	Governance: Policies and Procedures
High Level Audit Objective	The primary objective of this audit is to provide reasonable assurance that there are adequate and effective procedures and controls to ensure that the Medical Center policies and procedures are adequately documented, maintained and communicated.				
Observations Findings Recommendations	In order to develop a formal system for approving, cataloging, communicating, and monitoring policies we recommend that the Medical Center use a phased approach. The target implementation date for Phase I should be August 31, 2010. Implementation dates for subsequent phases will be determined during Phase I. a. Phase I – The first phase would involve establishing an oversight structure for policy management and developing a policy on policies b. Phase II – The second phase would include creating a central policy website and revising current policies and procedures. There are numerous design and content options for the policies and procedures website. We are providing various options to be considered. c. Phase III – The third phase would consist of determining a method for disseminating information about new and/or updated policies and ways to ensure that policies are updated on a timely basis.	Current Status	Incomplete/Ongoing The Executive Vice President of Business Affairs has not yet completed Phase I of establishing an oversight structure for policy management. Due date was 8/31/10, not yet completed.	Fiscal or Other Impact	Increase communication and visibility of numerous policies and procedures guiding the Medical Center

10:12 Emergency Preparedness

Report Number	10:12	Report Date	08.31.10	Name of Report	Emergency Preparedness
High Level Audit Objective	The primary objective of this audit is to provide the President and Board of Regents with reasonable assurance that the Office of Emergency Management and Business Continuity control activities ensure adequacy in emergency preparedness and compliance with UTS 172 requirements.				
Observations Findings Recommendations	As a result of our evaluation, we recommend the following activities to enhance the Medical Center's compliance with UTS 172 – a. The EOP should include a risk assessment/vulnerability analysis that is specific to the Medical Center. The risk assessment should include identification of all potential risks to the campus. Those risks will then be evaluated and ranked in the order they are most likely to occur on campus. UT Southwestern should develop a mitigation plan for mitigating those risks. The risk assessment should be formally reviewed, updated and approved by executive management every two years. b. The emergency management program should include a formal training plan that provides assurance that minimum requirements for training Medical Center personnel are met. Also, the training plan should include those specific requirements for training all specialized staff in their area for emergency management. The training plan should provide standards for both initial and annual/refresher training for these	Current Status	Incomplete/Ongoing Risk assessment, and formal training program to assure minimum training requirements for training Medical personnel met are due 2/1/11.	Fiscal or Other Impact	Provides reasonable assurance that the Office of Emergency Management and Business Continuity's control activities ensure adequacy in emergency preparedness and compliance with UTS 172 requirements

10:12 Emergency Preparedness, continued

Observations Findings Recommendations	Current Status	Fiscal or Other Impact
various groups. Finally, based on a wide variety of emergency scenarios, the training plan should include how often the Medical Center must run emergency test/drills to include some conducted on evening and weekends. c. The Emergency management program should include written documentation of all external agency arrangements which provide coverage to the University. The written external agency agreement should include – • Emergency contact names and 24-hour phone numbers • Services the agency can provide • Equipment the agency can provide • Restrictions on assistance • Reporting (staging) locations • Command relationships • Provision for annual review of agreement • Provision for involvement of the external agency in emergency situations and drills on campus • Provision for Medical Center to provide assistance in the event of a community disaster d. In order to further promote a seamless, comprehensive emergency operations approach, coordination specifics between the University Hospitals and the remainder of the Medical Center should be agreed to and formally documented.	Incomplete/Ongoing Manager of Emergency and Business Continuity is developing emergency management program for external agency arrangements, and documenting comprehensive operations approach between Hospitals and Medical Center. Due date 2/1/11.	Compliance with UTS 172.

10:12 Emergency Preparedness, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	e. The emergency management program should provide specific procedures for implementation of all recommendations resulting from post incident reviews. The Office of Emergency Management and Business Continuity should formalize follow-up procedures for all recommendations made and report timely on their implementation status to the Emergency Management Committee. f. Each year and after a significant change, the EOP should be formally reviewed, approved, signed by the President and dated. A distribution list showing locations and/or individuals who have copies of the plan should be maintained within the Office of Emergency Management and Business Continuity. Procedures for documenting changes and updates to the plan should be developed.		Incomplete/Ongoing Manager of Emergency and Business Continuity is developing procedures for post incident reviews, and ensuring that the EOP is reviewed and approved by the president annually. Due date 2/1/11		
	g. Continue to monitor UT System's progress toward implementation of a Safety and Security Audit (Peer Review) process. Ensure that the Medical Center receives a safety and security audit by August 2012 and every three years thereafter.		Incomplete/Ongoing Process to ensure the Medical Center receives its safety and security audit by UT System is being developed. Due date 8/2012.		

10:13 Grants Management

Report Number	10:13	Report Date	03.03.10	Name of Report	Grants Management
High Level Audit Objective	The primary objective of this audit is to provide the President and Board of Regents with reasonable assurance that there are adequate and effective controls for Grants Management to ensure that the Office of Grants Management is meeting its objectives and mission.				
Observations Findings Recommendations	**1. Monitoring controls for contracts need improvement.** Department contracting procedures and management reviews should be established. The following recommendations have been included to address the monitoring control weaknesses identified: • Substantive changes to standard contract language should receive review by UT System Office of General Counsel. • Submit contracts to UT System accordingly for all contracts that meet or exceed established thresholds outlined in UTS 145. • Establish a threshold for the number of amendments requiring legal review. After a certain number of amendments, the department should require legal review of contracts to determine whether the contract should be restated, a new agreement should be drafted or whether additional amendments are appropriate to ensure clarity of the agreement. • Establish controls over contract maintenance to ensure that all contracts can be easily located.	Current Status	Fully Implemented	Fiscal or Other Impact	Without a legal review for substantive changes and contracts for large amounts, institutional funds are at risk. Additionally, there is a risk of increased institutional liability if contract language and terms are not appropriate.

10:13 Grants Management, continued

Observations Findings Recommendations	2. Implement Cash Handling Controls To enhance cash handling controls, management should emphasize separation of duties by ensuring separation between the receiving office and opening of mailed checks to custody/deposit of checks to the Cash Management Office. All checks received by the department should be restrictively endorsed, recorded upon receipt in a check log, and authorized for deposit with management's signature. Once authorized, the custodian completes the check/cash transmittal form and delivers the check and the check/cash transmittal form to Cash Management. Cash Management signs a copy of the transmittal form, and the custodian files the form in her records. At the end of the month, management should reconcile the log to the signed copies of Check/Cash Transmittal Forms submitted to Cash Management for that month. The reconciliation would reveal any checks received that have not been deposited timely with Cash Management.	Current Status	Substantially Implemented. Director of Office of Cash management is in the process of finalizing separation of duties regarding handling of checks/cash, requiring restrictive endorsement of items, and reconciling the log to the signed copies of cash/check transmittal forms. Due date 11/1/10.	Fiscal or Other Impact	The documentation of transactions and the balancing of cash at all points of transfer are critical to maintain accuracy and safety of cash transactions.

10:13 Grants Management, continued

Observations Findings Recommendations	3. **Increase Automation for Grant Management Processes** We recommend consideration of investing in a robust automated pre-awards information system that can be used to aid in the complex federal grant proposal process and in the process of transferring applications between systems. The system would automate the current manual process and allow for tracking and monitoring of PI submission dates. Management should invest in a system that can assist in the collection of data, ensure accuracy in budget calculations, eliminate barriers to development and submission, integrate proposal data with other campus information systems and thus increase the efficiency of the pre-award processes.	Current Status	Incomplete/Ongoing Approval is pending from the VP for Research Administration. Date of completion, unknown.	Fiscal or Other Impact	Pertinent information may not be as easily identified, captured and potentially increasing the risk of lost award opportunities for the Medical Center.

10:17 UTS 155: Policies and Procedures Regarding MSRDP Business Operations and Governance

Report Number	10:17	Report Date	07.13.10	Name of Report	UTS 155: Policies & Procedures Regarding MSRDP Business Operations and Governance
High Level Audit Objective	The primary objective of this audit is to provide reasonable assurance that there are adequate and effective controls applies by MSRDP functions: • To ensure the Business Operations for MSRDP financial activities comply with UTS 155. • To ensure a system for governance (as articulated in the current MSRDP Bylaws of the Medical Center) by which the Faculty Practice Plan is directed and managed is adequate				
Observations Findings Recommendations	**MSRDP Business Operations** **1. Enhance Control and Management of Financial Reporting** To enhance overall financial reporting controls for MSRDP financial activity, MSRDP Finance should establish and implement written procedures which describe explicitly the steps required to accomplish and document the following for all financial reports used for key MSRDP financial analysis and decision-making. o Preparation o Review o Reconciliation o Approvals	Current Status	Fully Implemented	Fiscal or Other Impact	Non-compliance of the UT System Model Bylaws, Article 10.2, Sarbanes-Oxley Act prescribing for formal documented financial reporting and reconciliation procedures of financial activities.

10:17 UTS 155: Policies and Procedures Regarding MSRDP Business Operations and Governance, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	In addition, front-end capture of information and data from Epic Resolute should be clearly defined and included within the documented financial reporting processes. The process for documenting of operational procedures should include routine review, update and approval as changes in operations warrant. To further enhance MSRDP Finance Reporting responsibilities, we also recommend that the department cross-train key staff members on the various financial reporting functions and document within its standard operating procedures.	Current Status		Fiscal or Other Impact	
	MSRDP Governance **2. Update Management Signature of Authorization and Approval for Department Incentive Compensation Plans** As substantial changes (change in management, strategy, formulas, etc.) warrant, we recommend management develop a process to ensure department incentive compensation plans include updated signature of approval by Executive Management for such changes. These plans should be readily available, up-to-date and consistent at both the departmental level and executive level (Office of the Dean).	Current Status	Substantially Implemented Process for documenting changes to department incentive compensation plans is being finalized. Due date 11/1/10.	Fiscal or Other Impact	An up-to-date signature of approval is a sound control to document management's review and authorization.

10:17 UTS 155: Policies and Procedures Regarding MSRDP Business Operations and Governance, continued

Observations Findings Recommendations					
	3. Improve Frequency of Assembly for Faculty Compensation Committee To better fulfill responsibilities for establishing Faculty Practice Plan compensation-specific performance goals, the compensation committee is in the best position to assess the appropriate relationship between risk inherent in compensation arrangements and how that level of risk corresponds to the overall business strategy and competitive environment of the Medical Center. Thus, we recommend the Faculty Compensation Committee continue to meet as prescribed in its Bylaws. Management should seek guidance from the Office of the Executive Vice Chancellor for Health Affairs if semi-annual meeting for the Faculty Compensation Committee would be appropriate.	**Current Status**	Implemented	**Fiscal or Other Impact**	Failure to meet constitutes non-compliance with the MSRDP bylaws section 6.2, Meetings of Standing Committees.
	4. Obtain Signature Approval of Executive Vice Chancellor's Authorization for Faculty Compensation Plan In order to comply with Bylaws Article IX Faculty Compensation Plan (section 9.3 – Compensation Plan), we recommend management provide for authorization to the EVC, the most current Faculty Compensation Plan (approved by the President) that clearly describes processes to compensate faculty as documented within the Medical Center's most recent Policy for Components of Compensation (effective September 1, 2010). Furthermore, as substantial changes to the Compensation Plan warrant, management should obtain EVC approval as well.	**Current Status**	Incomplete/Ongoing Executive VP for Health System Affairs is in the process of developing the Faculty Compensation Plan and obtaining approval of changes to the Plan. Due date 4/1/11.	**Fiscal or Other Impact**	Failure to obtain signature constitutes non- compliance with MSRDP By-laws causing an increased perception in lack of transparency of compensation activities within the Medical Center.

10:17 UTS 155: Policies and Procedures Regarding MSRDP Business Operations and Governance, continued

Observations Findings Recommendations	**5. Facilitate MSRDP Faculty Practice Plan Communication(s) to Membership** Given the size, complexity and decentralized nature of the Medical Center, it is evident that the demands to keep stakeholders of the Plan informed in a timely manner with information that is accurate, reliable and transparent are encompassing. The current environment also represents an opportunity for management to continue to encourage and seek input from various stakeholders within the Plan. With online resources available to our Board, sub-committee members and faculty, it is time efficient and cost effective to keep all interested members informed about Board activities. Thus, we recommend management utilize the Medical Center's intranet website by creating a Faculty Practice Plan web page. Upon the Office of Legal Affairs review and approval, the web page can be used to centralize minutes, meeting notices, agendas, faculty comments and various communications (i.e. report of Board/sub-committee actions, etc.) to keep interested faculty members informed. Furthermore, we recommend the Assistant Vice President of Compliance and the Chief Audit Executive report at least annually to the Board on related risk management topics important to the Plan and its membership.	Current Status	Substantially Implemented. Creation of Faculty Practice webpage is in process. Due Date 12/31/10.	Fiscal or Other Impact	Promotes increased communication of Faculty Practice Plan activities to membership.

10:18 UTS 155: Policies & Procedures Regarding Southwestern School of Health Professions Faculty Service, Research and Development Plan (FSP) Business Operations

Report Number	10.18	Report Date	04.05.10	Name of Report	UTS 155: Policies & Procedures Regarding Southwestern School of Health Professions Faculty Service, Research and Development Plan (FSP) Business Operations
High Level Audit Objective	The primary objective of this audit is to provide the President and Board of Regents with reasonable assurance that he overall environment in which the FSP is currently operating has adequate and effective controls.				
Observations Findings Recommendations	**Governance** The Southwestern School of Health Professions FSP should revise their bylaws. The revisions will be made and proved by the Board of Directors and passed on to UTSW administration for approval.	Current Status	Fully Implemented	Fiscal or Other Impact	Failure to revise bylaws constitutes non-compliance with UT System approved model bylaws format.
	Central Operations Manual Update Update the FSP Central Operations Manual (including the FSP Billing Compliance Plan) and distribute to all members and appropriate individuals to ensure business operations are complying with laws, regulations, and contracts. A formal review schedule should be established to ensure that these important policies and procedures are kept current.	Current Status	Substantially Implemented Operations Manual is in process of update.	Fiscal or Other Impact	Non-compliance with UTS 155.

10:18 UTS 155: Policies & Procedures Regarding Southwestern School of Health Professions Faculty Service, Research and Development Plan (FSP) Business Operations, continued

Observations Findings Recommendations	Current Status	Fiscal or Other Impact
Update Financial Reporting Procedures Documentation 1. Non-compliance issues with EPIC Resolute reporting guidelines should be formally presented to senior management and addressed in a timely manner. Until EPIC Resolute reporting issues are corrected, we recommend management develop a manual work around or ad-hoc report approved by senior management to ensure front desk professional and technical billings and related financial activity is properly and timely accounted for. 2. To ensure full compliance with prescribed UT System Model By-Laws and embrace SOX legislation, we recommend that the SSHP EPIC financial reporting procedures and processes be formally documented to increase transparency, governance, and accountability of SSHP Practice Plan financial activities. This should include the various financial (appointments & sign-ins to charges and collections) reconciliation points for all levels: • Billing Coordinators • Billing Managers • SSHP Director, Dean's Office 3. Require all patients at the Spinal Cord Injury Lab and Main Physical Therapy Clinic (CB1) to place their signature on the sign-in sheet/label when they arrive to ensure compliance with the EPIC Daily Front Office Clinic Reconciliation Checklist.	Item 3 -Fully Implemented Items 1&2- Ongoing/Incomplete Epic Resolute reporting guidelines are being addressed within MSRDP Business Operations.	Non-compliance of formally documented financial reporting and reconciliation procedures as prescribed by the UT System Model Bylaws, Article 10.2, Sarbanes-Oxley Act.

10:19 Family Practice and Primary Care Residency Program Grants

<table>
<tr><th>Report Number</th><th>10:19</th><th>Report Date</th><th>08.11.10</th><th>Name of Report</th><th colspan="3">Family Practice and Primary Care Residency Program Grants</th></tr>
<tr><td>High Level Audit Objective</td><td colspan="7">Internal Audit (IA) performed the engagement to satisfy the audit requirements of the Coordinating board and provide reasonable assurance that there are adequate and effective controls related to the administration of the family Practice and Primary Care grants.</td></tr>
<tr><td>Observations
Findings
Recommendations</td><td colspan="3">1. Compliance
a. Verify the residents identified within the grant were participating in the programs
i. We recommend that the Residency Program Director for the Department of Family and Community Medicine (Family Medicine) review the grant agreement and consult with Post Awards to determine the appropriate action necessary to correct the FY09 error. Corrective action should be documented and communicated to Post Awards and IA.
ii. Family Medicine should document and implement appropriate processes and procedures to ensure the accuracy of the certified resident roster for future awards and compliance with all aspects of the grant agreement. Processes and procedures should include documentation of the following:</td><td>Current Status</td><td>Fully Implemented</td><td>Fiscal or Other Impact</td><td>Compliance with Texas Coordinating Board requirements.</td></tr>
</table>

10:19 Family Practice and Primary Care Residency Program Grants, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	1.) A review of each resident's appointment/reappointment letter in effect on the certification date to determine if the resident's contractual obligation for the fiscal year of the award meets the minimum required time and is otherwise eligible under the terms of the agreement. 2.) A review of the actual time the residents included in the certified resident roster in the grant application actually trained in the program during the fiscal year of the grant. This review should be performed and documented prior to the submission of the final report to the Coordinating Board to ensure compliance with the agreement terms and allow for modification as necessary to the final report for any refunds that may be necessary. 3.) Provide documentation supporting the executed processes and procedures and related results to the Office of Post Awards (Post Awards) as part of the preparation of the final financial report.		Fully Implemented		

10:19 Family Practice and Primary Care Residency Program Grants, continued

Observations Findings Recommendations					
	b. Determine if the reported Family Practice and Primary Care grant expenditures are in compliance with policies and procedures of the Medical Center and Coordinating Board grant guidelines and contract terms. We recommend before expenditures charged to the Family Practice grant are approved that the reviewer and/or approver ensure that each of the expenditures adheres to the guidelines set forth in the Family Practice Guidelines for Funding Operational and Support Programs. Additionally, there should be validation that the expenditure's purpose conforms to purposes set forth in the agreement. Communication of this process needs to be documented via policy or memo.	Current Status	Fully Implemented	Fiscal or Other Impact	Financial controls assist management to use accurate, timely financial information.
	c. Determine if the grant agreement between the residency programs and the Coordinating Board for FY09 had been approved by the required parties. We recommend that Family Medicine ensure that before commencement of activities under any agreement or disbursement or receipt of funds for services received or performed, the department must first ensure that the agreement is reviewed by the required parties of the Medical Center and executed by the authorized representative of the Medical Center as stated in the Medical Center policies. Communication of this process should be documented for future reference.	Current Status	Fully Implemented	Fiscal or Other Impact	Agreements that have not been signed by the proper authorized representative of UT Southwestern and/or have not received UT System approval could potentially be considered invalid.

10:19 Family Practice and Primary Care Residency Program Grants, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	2. **Income and Expenditure Review – Determine if the financial reports represent accurate and complete information related to the grants.** We recommend that Post Awards ensure that the draft IERs are prepared and distributed for internal review by December 1. This will ensure enough time is permitted for the Coordinating Board required audit and for Post Awards to address any changes the residency programs may request related to the IERs before submission to the Coordinating Board by the December 31 due date.		Fully Implemented		Compliance with Texas Coordinating Board award.

10:21 Ethics Objectives, Programs and Activities

<table>
<tr><th>Report Number</th><th>10:21</th><th>Report Date</th><th>05.27.10</th><th>Name of Report</th><th colspan="3">Ethics Objectives, Programs and Activities</th></tr>
<tr><td>High Level Audit Objective</td><td colspan="7">The primary objective of this audit is to provide reasonable assurance that the design, implementation, and effectiveness of the Medical Center's ethics-related objectives, programs and activities comply with applicable laws and regulations and are consistent with ethics program elements as outlined in the Federal Sentencing Guidelines (Federal Sentencing Guidelines §8B2.1 Effective Compliance and Ethics Program).</td></tr>
<tr><td>Observations Findings Recommendations</td><td colspan="3">1. Formalize Organizational Ethics Program through Creation of an Ethics Plan
To enhance current efforts and build a robust organizational ethics program within the Medical Center, we recommend that the current Ethics Officer work in conjunction with Institutional Compliance to develop an Organizational Ethics Plan that promotes organizational ethics within the Medical Center culture, as well as reflecting Management's strategies outlined in recommendations made within the recent Strategic Initiatives for the Medical Center. More specifically, we recommend the development of an Ethics Plan to include:
• The Mission and Ethical Values Framework of the Medical Center
• The Goals and Purpose of an Ethics Program
• The Elements and Structure of the Ethics Program, to include –
o Oversight – To ensure authority of the Program's content, operation, implementation and effectiveness. Most importantly, this section should specify the "point person" for employees to look to for integrating ethics into decision-making processes and behavior.</td><td>Current Status</td><td>Substantially Implemented
Ethics Plan is in process. Due date 12/31/10.</td><td>Fiscal or Other Impact</td><td>Increase coordination and communication between the Ethics Officer and Institutional Compliance to insure adequate coverage of ethic-related risks.</td></tr>
</table>

10:21 Ethics Objectives, Programs and Activities, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	○ Policies and Procedures – To develop and communicate ethical standards and procedures that are clear, concise, comprehensive, and accessible. To review current Medical Center policies involving ethical components. • Education and training to foster and maintain an ethical culture – Develop a documented annual training plan that will: ○ Raise awareness of the role for employees, as well as available resources; ○ Enhance sensitivity of employees to ethical issues; and ○ Assist employees to better understand legal and ethical dimensions unique to their role as an employee of the Medical Center. • Risk Assessment – Assess periodically the risk that certain types of criminal or other wrongful conduct may occur, as well as the steps necessary to prevent and detect inappropriate conduct. Also, in order to support a formal ethics program, we further recommend that the Executive Compliance Committee charter be amended to directly address its functions/responsibilities related to ethics. Once the Plan has been completed, the Ethics Officer should obtain approval of the Plan by executive management and by the Executive Compliance Committee.		Substantially Implemented. Amendment of Executive Committee charter to address ethics concems is in process. Due date 12/31/10.		Charter specifically communicates functions/responsibilities for management of ethics-related risks.

10:22 University Hospitals Quality Indicators

Report Number	10:22	Report Date	01.26.10	Name of Report	University Hospitals Quality Indicators
High Level Audit Objective	The primary objective of this audit is to provide reasonable assurance that the University Hospitals' Performance Improvement Initiative effectively manages risks related to monitoring of University Hospitals' quality indicators.				
Observations Findings Recommendations	**1. Improve monitoring practices to promote timely correction of deficiencies** To expedite notification to hospital physicians for noncompliance activities, we recommend management update department procedures to ensure notices for noncompliance are communicated to promote timely resolution and thus benefit overall patient care. Timeframes for analyst review and preparation of physician letters should be established and linked to analyst performance expectations. Additionally, timeframes for management review and sending letters to physicians should be established and monitored.	Current Status	Fully Implemented	Fiscal or Other Impact	Timely notification of physicians expedites corrective measures for compliance.

10:22 University Hospitals Quality Indicators, continued

	Recommendation		Status		Impact
	2. Expand the review process to promote continued accuracy in reporting of core measure data To enhance oversight functions, we recommend management • Update policies and procedures to define review activities for reportable quality indicators. • Require analysts to sign off for each quality indicator completed and require reviews of competed work by management (or a highly experienced analyst) with initial and date as evidence of review.	**Current Status**	Fully Implemented	**Fiscal or Other Impact**	Increased monitoring functions ensure key quality measures are reported accurately and completely.

10:23 Billing Compliance

Report Number	10:23	Report Date	02.24.10	Name of Report	Billing Compliance
High Level Audit Objective	The primary objective of this audit is to provide the President and Board of Regents with reasonable assurance that there are adequate and effective controls applied by the University's Billing Compliance functions: • To ensure all identified medical billing risks to the UT Southwestern Medical Center and its affiliated University Hospitals are appropriately managed. • To build compliance consciousness into daily operations through monitoring procedures and consistent application of corrective, restorative, and/or disciplinary actions in instances of non-compliance.				
Observations Findings Recommendations	**1. Hospital Billing Compliance had not established a framework to apply key elements of OIG Guidance for Hospitals** We recommend that the Hospital Billing Compliance program be restructured and designed to incorporate the OIG Supplemental Compliance Program Guidance for Hospitals published in the Federal Register, Vol. 70, No. 19. Additionally, we recommend consolidation of efforts to ensure complete coverage of University Hospitals billing compliance risks. We further recommend development of a cohesive annual risk assessment and corresponding audit plan. A monitoring system for the audit plan should be developed to ensure that planned audits are actually performed. Timely follow-up of audit results is needed to ensure corrective actions occur.	Current Status	Fully Implemented	Fiscal or Other Impact	Ensure key hospital billing risks are covered and duplicative efforts do not exist.

10:23 Billing Compliance, continued

	2. Professional Billing Compliance failures were not timely monitored Enforce the established timetable set forth in the Billing compliance Plan as authorized by the BCAC for handling depute resolutions. Additionally, the BCO will continue to perform quarterly reviews, irrespective of ongoing disputes over MDaudit™ scoring.		Fully Implemented		Increases compliance enforcement for errors revealed.

10:23 Billing Compliance, continued

Observations Findings Recommendations	Finding	Current Status	Status	Fiscal or Other Impact	Impact
	3. Systemic failure rates should be identified, reported and addressed at the department level In addition to the individual provider remediation process, systemic failure rates should be identified, reported and addressed at the department level. By immediately addressing non-compliance at the department level, recurring systemic failures may be prevented. The Billing Compliance Office (BCO) should calculate and monitor departments' billing compliance failure rates. Departments with high failure rates should receive immediate formal intervention at the department level to prevent recurring systemic billing compliance failure. The BCO should develop a formal structured training program centered on improving billing compliance scores at the departmental level. Audit scores and identified areas on non-compliance should be monitored at the departmental level to evaluate effectiveness of training. Additionally, departments with recurring systemic failure rates should be reported to the Billing Compliance Advisory Committee (BCAC) and the University Billing Compliance Committee (UBCC). The BCO should work with the BCAC and UBCC to plan for and manage additional departmental remediation efforts.		Fully Implemented		Increases training opportunities for departments on billing compliance principles thus expediting correction/improvement of failure rates.

10:23 Billing Compliance, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	4. Periodic reviews of MDaudit™ users rights should occur Management should work with the Database Administrator to: • Develop functionality-based user roles to ensure access granted to MDaudit™ users is based on the minimum amount of information required to perform their jobs. Until their functionality exists, log reviews should begin immediately to monitor changes make by users. • Implement a formal periodic review of user access rights (with a focus on changes in job responsibilities). • Review, remove and/or disable user access to MDaudit™ to reflect current authorized user needs or changes in role or employment status.		Fully Implemented		Ensure appropriate use of MD Audit (Medical Center's automated billing compliance audit tool) and safeguarding of its data.
	5. The Professional Billing Compliance Plan should be updated The Professional Billing Compliance Plan should be updated to reflect current practices, and to clarify and define roles and reporting structure of all Committees with oversight of Professional billing Compliance. Management should review the Plan on an annual basis and obtain committee approval for necessary revisions.		Fully Implemented		To accurately reflect the duties and responsibilities of the various groups that carry out hospital and physician compliance for the University.

10:24 Controlled Substances

<table>
<tr><th>Report Number</th><th>10:24</th><th>Report Date</th><th>10.21.10</th><th>Name of Report</th><th colspan="2">Controlled Substances</th></tr>
<tr><td>High Level Audit Objective</td><td colspan="6">The audit objective is to document and assess the adequacy of the control environment surrounding the handling, safeguarding and reporting of controlled substances to ensure the following:
• Reliability and integrity of reported controlled substances information (Objective A)
• Safeguarding of controlled substances from theft or misappropriation (Objective B)
• Compliance with laws, regulations and contracts (Objective C)</td></tr>
<tr><td>Observations Findings Recommendations</td><td colspan="2">1. Documentation of Controlled Substances Procedures
Based on our review and observation of controlled substances procedures at each pharmacy location, we recommend review and revision or development of controlled substances procedures to clarify requirements, deliverables, documentation and responsibility to promote consistency and standardization of processes across St. Paul and Zale Lipshy. Activity should be periodically reviewed to ensure compliance with policies and procedures.</td><td>Current Status</td><td>Substantially Completed. Due date 10/26/2010.

Controlled substance procedures review is in process.</td><td>Fiscal or Other Impact</td><td>The inadequate documentation of controlled substances procedures for the OR Satellite Pharmacies at St.Paul and Zale Lipshy University Hospitals promotes inconsistent application of expected controlled substances procedures across similar business functions. This increases the opportunity for diversion or inaccurate reporting of controlled substances.</td></tr>
</table>

10:24 Controlled Substances, continued

Observations Findings Recommendations	2. **Cancer Center Pharmacy – Improvement of the Control Environment** Based on results of our procedures at the Cancer Center Pharmacy, we recommend thorough review of the control environment surrounding controlled substances within the Cancer Center Pharmacy and immediate development of appropriate policies and procedures to adequately prevent theft, diversion or misappropriation of controlled substances. Procedures should include, but are not limited to the: • segregation of duties between the ordering, receiving, recording and reconciliation of controlled substances • safeguarding of all controlled substances through appropriate storage, • witnessing by second individuals of all receipts and transfers, • adequate documentation of inventory to indicate the accurate and complete inventory with identification and documentation of resolution for any discrepancies noted, • adequate record keeping which involves supporting documentation and management approval of all changes or revisions to inventory balances and • adequate record keeping which allows for immediate identification of discrepancies followed by immediate follow-up and resolution and corresponding documentation	Current Status	Segregation of duties- Implemented Safeguarding of Schedule III Midazolem- Implemented Development of procedures for Pyxis restocking Substantially Completed. Due Date October 31, 2010 Documentation of initial inventory post-process changes Substantially Completed. Due Date- October 31, 2010	Fiscal or Other Impact	An enhanced control environment ensures safeguarding against opportunities for misappropriation of controlled substances. Inadequate safeguarding and controls of controlled substances is in violation of the Controlled Substances Act and the Controlled Substances Security Manual as mandated by the U.S. Drug Enforcement Agency.

10:24 Controlled Substances, continued

Observations Findings Recommendations					
	3. Monitoring & Documentation of Transfers Between Pharmacies Based on results of our procedures performed, we recommend the revision of applicable policies to include documentation of procedures and recordkeeping requirements for all controlled substance transfers between pharmacies. Recordkeeping requirements should include all necessary documents to effectively trace the source and destination of controlled substances with proper management review to ensure accuracy and completeness. A documented periodic review or monitoring for compliance and reconciliation of activity between pharmacies should be performed.	**Current Status**	Incomplete/Ongoing Due Date 3/21/11 Recordkeeping requirements for all controlled substances between pharmacies is in process for review.	**Fiscal or Other Impact**	Increase monitoring of dispensed controlled substances to mitigate the opportunity for theft or loss without detection and creates risk of incorrect patient charges.
	4. St. Paul Pharmacy – Review of Discrepancy Resolution Based on results of our procedures related to the St. Paul Pharmacy, we recommend secondary review of discrepancy resolutions performed by the Narcotic Technician to include the Compare Report and any additional resolution of discrepancies indentified supported by revised policies and procedures. Secondary review should represent the verification and approval of discrepancies resolved accompanied by evidence that review was performed.	**Current Status**	Substantially Complete. Due Date 12/31/10. Secondary review of discrepancies is in process.	**Fiscal or Other Impact**	Secondary review of discrepancy resolution to ensure items was appropriately addressed to the satisfaction of management's authority.

10:24 Controlled Substances, continued

Observations Findings Recommendations	Observation		Current Status		Fiscal or Other Impact
	5. Monitoring of Controlled Substances after Dispensation Based on results of our procedures related to the monitoring of controlled substances, we recommend ongoing evaluation of automated methods and reporting to effectively monitor whether controlled substances were appropriately documented as administered to the patient or reflected in wastage or loss reporting. Consideration should be given to automated reports to allow for more timely capture and review of information needed to appropriately determine the accountability of controlled substances.	**Current Status**	Incomplete/Ongoing Due Date 3/21/11 Evaluation of automated methods of monitoring controlled substances is in process.	**Fiscal or Other Impact**	Inadequate methods to provide assurance that controlled substances dispensed were administered or properly disposed of increases the opportunity for theft or loss without detection and creates risk of incorrect patient charges.
	6. Controlled Substances Education Based on our review of education on controlled substances procedures communicated to Medical Center personnel, we recommend formal education of required controlled substances procedures to all Medical Center personnel: pharmacists, pharmacy technicians, nursing staff, practitioners, and other personnel with responsibility over controlled substances. Additional education specific to practitioners should be provided to emphasize practitioner responsibility in safeguarding controlled substances. Communication should be distributed annually with reference to regulations and institutional policies and procedures and should be incorporated into new employee orientation or training.	**Current Status**	Substantially Complete Due Date 12/31/10 Formal education of staff is in process.	**Fiscal or Other Impact**	Failure to educate Medical Center personnel on appropriate controlled substances procedures may result in the misinterpretation or less stringent application of required procedures.

10:25 Information Technology Governance – IIA Standards 2110.A2

<table>
<tr><td>Report Number</td><td>10:25</td><td>Report Date</td><td>08.25.10</td><td>Name of Report</td><td colspan="3">Information Technology Governance – IIA Standards 2110.A2</td></tr>
<tr><td>High Level Audit Objective</td><td colspan="7">The primary audit objective is to provide reasonable assurance that the Medical Center's IT governance structure is appropriate to support Medical Center strategies and objectives.</td></tr>
<tr><td>Observations Findings Recommendations</td><td colspan="3">1. Communication of Anticipated Project Implementation Dates
We agree that a formal communication of this type should be developed and distributed to the key project stakeholders across the organization. Some key elements to this communication will include:
• The project listing will include all Capital and Large non-capital projects that are currently being worked on by the IR department during the fiscal year. These projects will be identified by the project (work) type designation in the Planview Project Portfolio application. These work types are "5", for capital projects, and "4", for non-capital.
• This comprehensive list will include, at a minimum, the project title, brief description, IR project owner, project start date and anticipated "go-live" date.
• The frequency of distribution will be monthly.
• The recipients of this listing will include, but are not limited to, the members of all the key strategic and planning committees for the Information Resources.
• We will also make the best effort to include the project status of the PeopleSoft/ERP projects.</td><td>Current Status</td><td>Fully Implemented</td><td>Fiscal or Other Impact</td><td>Promotes full awareness of projects to project stakeholders.</td></tr>
</table>

10:25 Information Technology Governance – IIA Standards 2110.A2

Observations Findings Recommendations	The timeline for development of this listing will be to begin the draft and obtain sign-off on format and content during the month of September 2010. The target date for the first official publishing and distribution of this list will be Friday, October 8, 2010. This will allow for the first issuance of this communication to correlate with the first month of the new fiscal year. On-going, this report should be completed within the first full week of each month and will include all projects planned and active for that fiscal year.	Current Status		Fiscal or Other Impact	
	2. Information Security – Operational Review of Policies and Procedures • Information Security will perform and document a review of all Information Security policies. The focus of the review will be to ensure that current policies remain relevant to known operational processes and to the current IT environment. Results of the review will be documented for future reference. This review will be completed by December 31, 2010. • Information Security will modify procedure 400-05, Annual Information Security Policy Review Process, to include the objective of identifying operational or environmental changes. Resource constraints obviously will affect the assignment of reviewers, and we reserve the right to include this operational review as part of our annual external risk assessment. We will also improve the procedure document to include assignments of reviewers, and we will add references to 400-05, Annual Information Security Policy Review Process, to each	Current Status	Substantially Complete Review of all Information Security policies is in process. Due date 12/31/10	Fiscal or Other Impact	Ensures policies and procedures are up-to-date and meet management expectations.

10:25 Information Technology Governance – IIA Standards 2110.A2, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	individual Information Security policy. Agreed-to changes to the procedure and all policies will be completed.	Current Status		Fiscal or Other Impact	
	3. Information Security Policy 200-28 – Change Management a. The Acting Chief Information Security Officer will review policy 200-28 and compare the intent of the policy to the current change management processes. Variances will be discussed with appropriate operational personnel. Where gaps are identified between practice and written policy, a determination will be made to modify either practice or the policy. b. Exceptions identified from April and May 2010 change activity will be discussed with responsible individuals. Inappropriate use of the "Standard" change type is of special concern and will be discussed with all individuals who participate regularly in the change management process. Technical controls will be evaluated to determine if they can be reasonably implemented (i.e. prohibit use of "Standard" change type if downtime is entered).	Current Status	Substantially Complete Review of Information Security Policy 200-28 is near completion. Due date 10/31/10.	Fiscal or Other Impact	Insures compliance with internal policy on established change management procedures.

10:25 Information Technology Governance – IIA Standards 2110.A2, continued

Observations Findings Recommendations	Current Status		Fiscal or Other Impact	
4. Documentation of Policies and Procedures – Department of Client Services Client Services has an internal SharePoint site which includes a technical knowledge base referencing technical documentation for the Client Services staff. A section will be added detailing the requested information from Internal Audit. The policies and procedures will include: • Examples of each individual report. • Details regarding where and how data is retrieved. • Details outlining how reports are completed including the actual steps. • Details of other reports submitted by Quality Control and supervisors, and how reports are completed • Details of how data is interpreted and used for monitoring and evaluating individuals and performance of divisions within IR • List of due dates and the management who receives the reports.		Substantially Complete. Documentation of monitoring activities in process. Due date 11/1/10.		Documented policies and procedures increases awareness amongst stakeholders.

10:27 Epic Resolute Access Controls

Report Number	10:27	Report Date	09.16.10	Name of Report	Epic Resolute Access Controls
High Level Audit Objective	The objective of this audit was to assess the adequacy, efficiency, and effectiveness of system access controls for Epic Resolute. The audit focused primarily on whether an "active" status was appropriate. This audit did not analyze whether the levels of access were appropriate.				
Observations Findings Recommendations	**1. Epic Resolute Access Controls** To strengthen access controls for Epic Resolute we recommend the following: a. 144 Inactive Accounts – We recommend that IR Epic Technical Services research and clear the aged or otherwise inappropriate active IDs and continue with the current notification process. b. 69 Vendor Accounts – We recommend that IR Epic Technical Services immediately clear the inappropriate active IDs. We also recommend that IR Epic Technical Services begin performing a monthly validation of Epic Systems vendor accounts with the vendor. Additionally, IR Epic Technical Services should implement a policy approved by IR management and formalize procedures that specify the documentation and approval requirements for adding a vendor user ID to the Medical Center Epic System. c. 3 Contractor Accounts – We recommend that the 3 contractor IDs be soft-deleted in Epic. We also recommend that the IR sponsors for these contractors receive a reminder of the Medical Center HR clearance timeframe and notification process for contractors.	Current Status	Fully Implemented	Fiscal or Other Impact	Accounts in "active" status, even if actually unused, are a potential door for unauthorized access to systems. The Epic Suite holds protected health information (PHI) and other privileged information which the Medical Center is obligated to protect.

10:27 Epic Resolute Access Controls, continued

Observations Findings Recommendations					
	d. 1 Test Analyst – The test analyst ID should be soft deleted in Epic. e. 9 Generic Test Accounts – The generic test account IDs should be soft deleted in Epic. f. 1 Generic Interface Account – The generic interface account should be soft deleted in Epic.	Current Status		Fiscal or Other Impact	
	2. Follow-up on Prior Audits Audit standards require that we follow up on prior audit recommendations. Audit 0909.01 Annual Financial Review had one recommendation related to formal change management procedures, which was found to be implemented during the 1030 Follow-up Audits Report.	Current Status	Fully Implemented	Fiscal or Other Impact	N/A

This completes the List of Audits Completed for FY 2010.

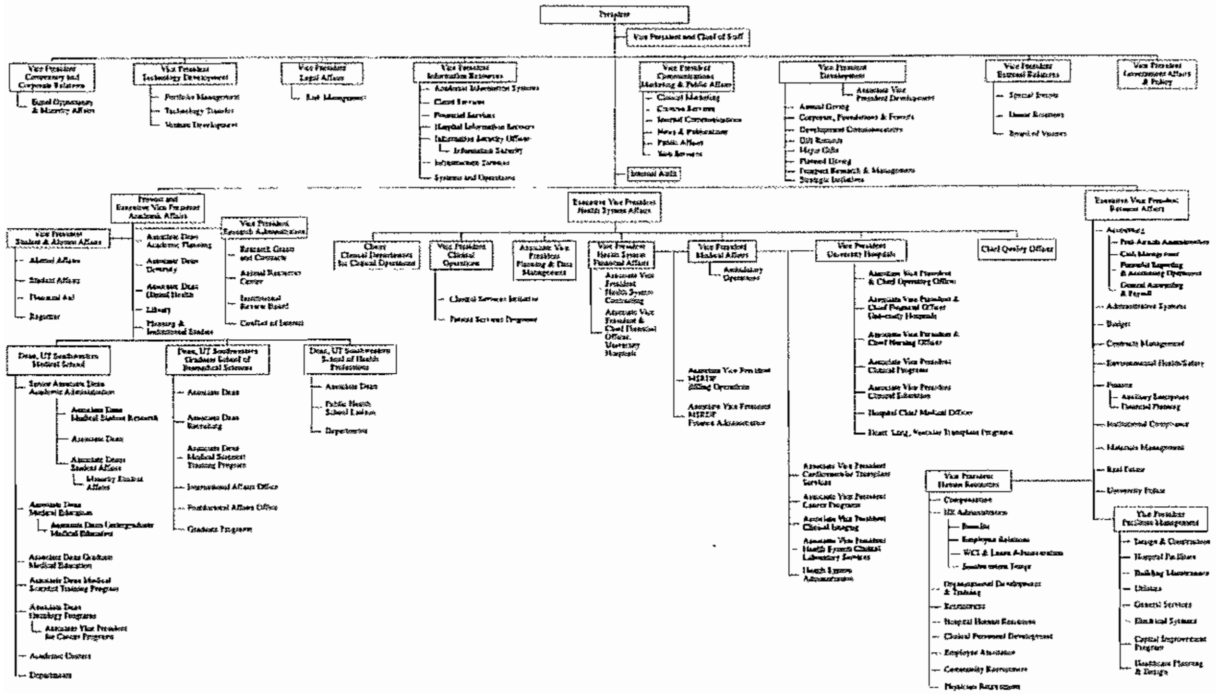
IV. List of Consulting and Non-audit Services Completed

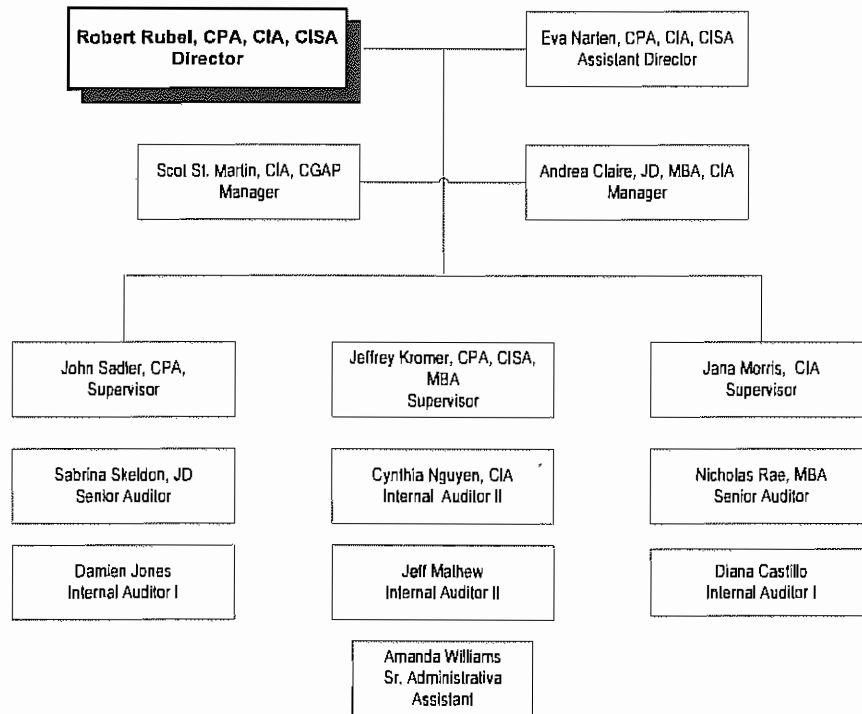
P10- No Reports issued for Planned Projects

Report Number		Report Date		Name of Report			
High Level Audit Objective							
Observations Findings Recommendations				Current Status		Fiscal or Other Impact	

This completes the List of Consulting and Non-audit Services Completed for FY 2010.

V. Organizational Chart





UT Southwestern Medical Center's Internal Audit Department reports to the UT Southwestern Internal Audit committee on a quarterly basis.

VI. Report on Other Internal Audit Activities

Activity	Impact
Performed reviews of complaints received through Medical Center's *EthicsLine*.	Provides the Medical Center with investigation resources.
Conducted facilitated risk assessment workshops	Collaborates with Medical Center management to provide an enterprise risk management process for the Medical Center
Conducted training for Medical Center employees on how to reconcile their departmental accounts	Provides Medical Center employees with guidance on how to reconcile their departmental accounts to minimize errors and irregularities in the normal course of business activities.
Fraud Analysis	Provides independent consultation and evaluation tools to management for monitoring and detection of fraudulent activities.
External Quality Assurance Reviews	Internal Audit Management participated in the following external quality assurance reviews for- • The University of Texas at Dallas • The University of Texas Health Center at Tyler
PeopleSoft Implementation	Provides independent consultation and guidance of internal controls for process flows within PeopleSoft applications implementation.
Business Resumption and Disaster Recovery Planning	Provides independent consultation and guidance to help Medical Center address Emergency preparedness and Business Continuity risks.
Security and Confidentiality Committee for HIPAA implementation	Provides consultation and guidance in the development of standards and procedures for the security of patient information per HIPAA guidelines for each institution.
Billing Oversight Committee	Addresses contemporary billing issues, e.g., AR statistics, collection reports, Medicaid issues, and management initiatives such as fee schedule analysis.
Coordination of External Audits	Provides operational support to the State Auditor's Office A-133 audit and Statewide Audit and financial audit

VII. Internal Audit Plan for Fiscal Year 2011

Audit #	FY 2011 Audit Plan Audit/Project	Budgeted Hours	% of Total	Priority Hours	% of Total	Description
	Financial Audits *UT System Requested/Externally Required Audits*					
11:01.01	FY2010 UTS Financial Statement Audit - Financial (YE)	800		800		Perform UT System developed year-end procedures for the FY2010 Annual Financial Report. Procedures also include review of the MSRDP Schedule D-6 for accuracy and completeness.
11:01.02	FY2010 UTS Financial Statement Audit - IT (YE)	600		600		Perform UT System developed year-end procedures for the FY2010 Annual Financial Report. Procedures also include review of PeopleSoft application controls.
11:02	FY2011 UTS Financial Statement Audit (Interim)	300		300		Perform UT System developed interim procedures for the FY2011 Annual Financial Report. Includes both financial and IT work.
11:03	Presidential Housing, Travel & Entertainment Expenses	150		150		Review budgeting for charitable giving, expense reporting (excluding travel paid for by third party and institutional entertainment), and approval of expenditures and reasonably following state guidelines.
11:04	Joint Admission Medical Program (Biennial Requirement)	150		150		Review the Joint Admission Medical Program (biennial requirement)

11:05	FY2010 National Pediatric Infectious Diseases Foundation AFR	200		200		Review the National Pediatric Infectious Diseases Foundation final Annual Financial Report
	Risk Based Tier One Audits					
11:06	Human Resources - Benefits & Leave Management	600		600		Review processes for allocating voluntary retirement dollars to ensure accuracy and adequacy of supporting documentation. Additionally, review processes for departmental management of FMLA, VSL, leave of absence, and compensatory time.
11:07	Buy Card Management	300		300		Review buy card processes for adequacy of controls.
	Carryforward Audits	100		100		
	Financial Audits Subtotal	**3200**	**18%**	**3200**	**21%**	
	Operational Audits *Risk Based Tier One Audits*					
11:08	Patient Payments (Time of Service)	600		600		Review Ambulatory and University Hospital payment processing to ensure that adequate controls exist for handling cash, protecting credit card/checking account information, and reconciling cash to daily patient encounters.
11:09	Research Laboratory Oversight	600		600		Review and assess the adequacy of laboratory oversight controls to determine if proper processes are in place to govem laboratory practices including safety and chemical inventory procedures.

11:10	MSRDP Contract Administration	400		0		Review departmental operations for MSRDP Contracting and Provider Enrollment.
	Operational Audits (cont'd) *Risk Based Tier Two Audits*					
11:11	Animal Resource Center	400		0		Determine if the animal housing environmental conditions in the Animal Resource Center and the laboratories is adequate
11:12	Pathology Labs/Veripath	600		600		Operations and patient safety for UTSW labs and contracted lab services (Veripath).
11:13	CVIR/Cath Lab	600		600		Review CVIR/Cath Lab departmental operations, including inventories, patient safety, and policies.
11:14	*Change in Management Audits*	400		0		Perform two change in management reviews, as needed.
	Carryforward Audits	150		150		
	Operational Audits Subtotal	**3750**	**21%**	**2550**	**17%**	
	Compliance Audits *UT System Requested/Externally Required Audits*					
11:15	THECB Medical and Graduate Medical Education Programs	300		300		Review Higher Education Coordinating Board required programs
11:16	FY11 Practice Plan Medical Billing Compliance - UT System Assistance	200		200		Provide assistance to the UT System Audit Office on the review of medical billing compliance
11:17	Institutional Compliance Program	300		300		Evaluate the elements of the institution's Compliance Program.

11:18	Effort Reporting	600		600		Assess the accuracy of time and effort reporting
	Risk Based Tier Two Audits					
11:19	Clinical Trials Billing	600		600		Determine if the clinical trials billing control environment adequately supports complete and accurate research bills and safeguards against fraudulent claims
	Carryfoward Audits	100		100		
	Compliance Audits Subtotal	**2100**	**12%**	**2100**	**14%**	
	Information Technology Audits *UT System Requested/Externally Required Audits*					
11:20	Information Security	600		600		Assess the accuracy of the institution's Information Security Office (ISO) Information Security Program Index (ISPI) utilizing UT System-provided procedures.
11:21	TAC 202 Compliance Audit (Biennial Requirement)	200		200		Perform the Texas Administrative Code 202 Information Security Standards Audit (Biennial Requirement)
11:22	Campus Wireless	300		300		Assist UT System in assessing the adequacy of campus wireless access controls.
	Risk Based Tier Two Audits					

11:23	Electronic Medical Record Controls	600		600		Determine if electronic medical record controls adequately support medical record security and integrity. Review would include assessing electronic medical record access applications (CPOE, hand-held devices, MyChart, etc.).
11:24	Epic Interfaces	600		600		Determine if Epic interface controls from hospital operations exist to ensure the accurate and complete transfer of information.
	Carryfoward Audits	100		100		
	Information Technology Subtotal	**2400**	**14%**	**2400**	**16%**	
11:25	***Follow-up Audits***	**500**	**3%**	**500**	**3%**	
	Projects *External Assistance*					
P11:01	UT System Requests	200		200		Provide assistance to the UT System Audit Office on any requests throughout the fiscal year.
P11:02	FY10 SAO A-133 & Statewide Financial Audit Assistance	500		500		Assist the State Auditor's Office in the A-133 Federal Audit and the financial portion of the statewide single audit (FY10)
	Audit Projects					
P11:03	PeopleSoft Modules	1400		1000		Provide continual review, assistance and input on various PeopleSoft modules
P11:04	FY10 LBB Performance Measures	200		200		Perform review of the LBB Performance Measures
	Consulting Projects					

P11:05	Reserve for Special Requests/Investigations	1200		800		Review ethics line and other special requests (including fraud considerations and ARRA Monitoring). Siemens SAS 70. Also includes two consulting projects (TBD).
	Other Projects					
P11:06	Continuous Monitoring	800		400		Develop continuous monitoring techniques utilizing ACL audit software. Continuous monitoring would include high risk areas for fraud.
P11:07	Requests for Information/Assistance	400		400		
P11:08	Internal Audit Annual Report	100		100		
P11:09	FY12 Annual Audit Plan & Risk Assessment	400		400		
P11:10	Internal Audit Committee	400		400		
	Projects Subtotal	**5600**	**32%**	**4400**	**29%**	
	Total Hours	**17550**	**100%**	**15150**	**100%**	
				Percentage Priority of Budgeted Hours	**100%**	
				Percentage Priority Hours to Total Budgeted Hours	**86%**	

Note: Total Priority hours should be at least 80% of Total Budgeted Hours

Total Available Audit 17586

Hours	
Less Total Hours	17550
Remaining Audit Hours Available	36

VIII. External Audit Services

The following is a list of audits completed by outside agencies at the Medical Center in FY2009.

- State Auditor's Office FY2009 Federal A-133 Audit
- State Auditor's Office FY2009 Statewide Financial Audit
- Weaver and Tidwell, LLP's FY2009 Moncrief Cancer Center and Moncrief Cancer Center Foundation Financial Audit
- KPMG's FY2009 UT Southwestern Health Systems (UTSHS) audit
- FY2009 UT System Financial Audit
- Office of Texas State Comptroller- Post Payment Audit
- Office of Texas State Comptroller- Post Payment Audit (ARRA payment transactions)

IX. Reporting Suspected Fraud and Abuse

- Fraud Reporting - Article IX, Section 17.05, the General Appropriations Act (81st Legislature)
- Reporting Requirements - Article XII, Section 5(c), the General Appropriations Act (81st Legislature).

  Implemented - UTSW web-site complies with requirements.