Fairfax County Internal Audit Office

Fairfax-Falls Church Community Services Board/
Department of Administration for Human Services
Medicaid Billing and Collection Audit
Final Report

May 2017

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Introduction

The Fairfax-Falls Church Community Services Board (CSB) provides mental health, substance abuse and developmental disability services to Medicaid recipients, among others. Medicaid is a federal government program that funds healthcare services to individuals and families with low income and limited resources. Medicaid is jointly funded by state and federal governments, but administered by state governments. The Virginia Department of Medical Assistances Services (DMAS) administers the Virginia Medicaid program. CSB documents services provided in its Electronic Health Record (EHR) system, Credible. On CSB's behalf, the Department of Administration for Human Services (DAHS) files claims for payment of services to various payers, including DMAS. We noted fiscal year 2016 Medicaid revenue at approximately $11.1 million an increase from $10.7 million in fiscal year 2015.

Executive Summary

Our audit was performed to determine the adequacy of controls over billings and collections for CSB Medicaid services. We found that processed billings were performed timely and in accordance with the established internal rates; proper segregation of duties was in place; and there appeared to be adequate controls over the client intake process. We also found that follow-up on outstanding receivables and disallowed claims was adequate. However, we noted the following control weaknesses:

- Medicaid service claims of approximately $482,000 were rejected in FY 2015 due to noncompliance with Medicaid preauthorization requirements. Medicaid service claims that do not comply with preauthorization requirements cannot be resubmitted for payment. It appeared that the patient records in the EHR system, Credible, had service preauthorization alert notifications that were not used effectively. In addition, staff should not have billed DMAS for services rendered by the CSB that did not meet Medicaid's preauthorization requirements.

- Revenue reconciliations of Credible to the County's Fairfax County Unified System (FOCUS) were not performed. County policy requires agencies perform monthly reconciliations.

- Management supervision of service provider compliance with Medicaid requirements was not adequate. CSB found that a former service provider failed to document compliance with Medicaid service requirements over a six-year period, which resulted in a $231,488 Medicaid refund payment. CSB also determined that another service provider was noncompliant with Medicaid requirements for a period of one-and-a-half years.

- Credible system controls were inadequate for Medicaid service compliance. Credible has an alert system to inform service providers of Medicaid service deadlines, but the alert does not directly target the service provider concerned. The function sends alerts to the service provider, supervisor and all other team

members with system access. CSB should consult with the Credible vendor about the cost to update the alert function to only notify the employee and their supervisor of their upcoming deadlines. This would reduce the number of manual supervisory client case file reviews and Medicaid noncompliance issues that resulted in refund payments.

- Controls over maintaining the documentation for Medicaid refunds were weak. Documentation to verify the accuracy and support the $231,488 Medicaid refund was not provided in a timely manner and readily available for review.

Scope and Objectives

This audit was performed as part of our fiscal year 2015 Annual Audit Plan and was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The audit covered the period of July 1, 2014, through June 30, 2015, and our audit objectives were to determine that:

- Proper segregation of duties and management oversight existed.
- All revenue due was billed.
- Billings were accurate and timely.
- Revenues were collected and reconciled in an accurate and timely manner.
- Adequate written policies, procedures and training existed for Medicaid billings.

Methodology

Our audit approach included interviewing CSB management and staff of areas responsible for client intake, client services and Credible system administration; and, DAHS staff for billing, recording and collection of revenue. We conducted walk-throughs of business processes; analyzed claims reports; and performed test work on a sample of 65 adjusted and rejected Medicaid claims. We also obtained and reviewed sample billing and recording documentation; Credible system screen prints and reports; and written policies and procedures to obtain an understanding of the business processes and controls in place.

Findings, Recommendations, and Management Response

1. Medicaid Claim Rejections

Medicaid claims for CSB services totaling $482,029 were rejected for the fiscal year 2015 (July 1, 2014 through June 30, 2015), because the required preauthorizations were not obtained prior to billing DMAS for services rendered. The rejected claims included $232,468 for case management services and $151,158 for crisis intervention services, while the remaining $98,403 included a variety of other services. Claims rejected due to lack of preauthorization cannot be resubmitted for payment. The Credible EHR system provides service preauthorization alerts however, it appears these alerts were not activated for CSB service providers and DAHS billing staff to utilize. Failure to comply with Medicaid claim preauthorization requirements results in uncollectable claims and loss of revenue.

Recommendation: In order to increase compliance with Medicaid's service preauthorization requirements and reduce the revenue lost due to noncompliance, we recommend CSB activate the preauthorization service alerts provided by the Credible EHR system. These service alerts should be available to both CSB service providers and DAHS staff who process billing. This will notify CSB service providers to obtain missing preauthorizations, enter them into Credible and alert DAHS billing staff to contact CSB staff for the information before billing the claim to DMAS.

Management Response: CSB and DAHS staff will review Medicaid requirements, Credible functionality, and internal business processes related to preauthorization. Based on a cost/benefit analysis, CSB and DAHS will implement a business process improvement plan, update policies and procedures, and implement training to ensure compliance and improve collections. Management anticipates completing this action by October 1, 2017.

2. Revenue Reconciliation of Credible to FOCUS

Reconciliation of CSB's Credible EHR system to FOCUS was not being performed. Documentation was provided to support Credible and FOCUS revenue entries; however, revenue recorded in the two systems was not reconciled.

The County's *Reconciliation of Financial Transactions* policy Accounting Technical Bulletin (ATB 020) requires County agencies perform monthly reconciliations to ensure the validity and accuracy of all transactions. The County's *Guidelines for Financial and Accounting Records Retention* (ATB 10040) requires documentation for reconciliations be maintained on file for at least three years.

The reconciliation of Credible to FOCUS helps prevent accounting errors, and detects unauthorized and improper transactions while ensuring all revenue due to the County is received and accurately posted.

Recommendation: We recommend CSB perform monthly revenue reconciliations of Credible to FOCUS that account for all differences and maintain the documentation for at least three years.

Management Response: DAHS staff will develop a methodology and in collaboration with CSB staff, review Credible functionality related to monthly reconciliation of financial transactions between Credible and FOCUS. Based on a cost/benefit analysis, DAHS will develop and implement a reconciliation plan to ensure compliance with *Reconciliation of Financial Transactions Policy Accounting Technical Bulletin* (ATB 020). Management anticipates completing this action by October 1, 2017.

It should be noted that the Health and Human Services (HHS) system is engaged in a five-year planning initiative to create an integrated information technology system anticipated to be used by all HHS agencies. The new system is anticipated to include interfaces with FOCUS to streamline operations and meet various financial management requirements, such as monthly reconciliation.

3. Control Weakness Over Compliance to Medicaid Service Requirements

During our audit, CSB determined that a former service provider, despite receiving multiple work- improvement-plans from CSB supervisors, did not comply with the Medicaid service requirements over a period of six years, which resulted in a $231,488 refund to Medicaid.

Subsequently, CSB management identified another service provider on a work-improvement-plan who was not meeting the Medicaid service requirements over a period of one-and-a-half years. At the close of our audit, CSB had not determined the refund amount due to DMAS as a result of this service provider's noncompliance. Internal Audit reviewed the processes leading up to these incidents and found the following control weaknesses:

Management oversight of service provider compliance with Medicaid service requirements was insufficient. CSB did not have an effective written monitoring process to ensure service providers adequately documented compliance with Medicaid client communications and service plan requirements in the system. This was due to heavy workloads and inadequate automated system controls that made monitoring deadlines very time consuming and cumbersome.

Credible EHR system contains an alert that has the ability to inform users when Medicaid service requirements are in danger of bypassing deadlines. However, this function sends noncompliant alerts to *all* team members with system access instead of only to the supervisor and service provider affected.

Since the system alert function was turned off, CSB supervisors did not receive alerts informing them of Medicaid requirements prior to deadlines. This forced them to filter through large volumes of data searching for service requirements that had or were

about to miss Medicaid deadlines. This increased the risk of deadlines not being met that would result in lost revenue.

Medicaid regulations require service providers perform and adequately document client services in their case files to receive payment for services rendered. Client meetings and service plan updates are required on a quarterly basis to ensure billability. Failure to perform and properly document compliance with Medicaid service requirements results in rejection of billable services and loss of revenue.

Recommendation: We recommend CSB develop written policies and procedures outlining the timely management of client case file reviews to ensure service providers are complying with and properly inputting Medicaid requirements into the system. All client case files for employees in work-improvement-plans should be reviewed by management prior to Medicaid billings.

In addition, CSB should consider consulting with the Credible system vendor regarding the cost and benefit of updating system controls to enhance management's ability to monitor service provider compliance with Medicaid requirements and determine if the benefits outweigh the costs. Credible system controls would give CSB management the ability to analyze and monitor a large volume of Medicaid client transactions for service provider compliance with Medicaid requirements more efficiently and effectively than a manual process. This would improve compliance rates, reduce human resource costs and prevent past issues of noncompliance that lead to Medicaid refunds.

At a minimum, CSB should consider updating the Credible Medicaid compliance alert function to send messages only to the service provider involved and his/her supervisor. This would ensure service providers are alerted to upcoming deadlines and enhance management's ability to monitor compliance to Medicaid requirements.

Management Response: CSB will meet with Credible Behavioral Health staff to explore current system controls available in the application's functionality to enhance management's ability to monitor service provider compliance with Medicaid requirements. CSB will consult with other CSBs in the Commonwealth that use Credible and determine how they may be using the application to monitor service provider compliance with Medicaid requirements. CSB will also explore the use of notification triggers within Credible to alert affected service providers and their immediate supervisor of pending deadlines to be compliant with Medicaid requirements. Notifications will be tested, then appropriately incorporated into the production application. Staff will also be properly trained on the effective use of notifications in their normal daily operations of serving clients. Management anticipates completing these actions by July 1, 2017.

4. Supporting Documentation for Medicaid Refunds

Controls over maintaining the documentation for Medicaid refunds were weak. Documentation to verify the accuracy and support the $231,488 Medicaid refund was not provided in a timely manner and readily available for review. Multiple requests were made for the information. Initial requests for documentation resulted in reports in which the Medicaid refund payment amounts did not agree with the amount paid on the check. Eventually, IAO had to perform our own analysis and reconciliation on the final set of Medicaid service transaction reports provided to support the refunded amount. We were able to reconcile them within a $5,246 variance and requested that CSB staff follow up on the variance and provide an explanation. CSB staff reviewed our follow-up inquiries and was able to explain $1,328 of the variance and determined that they had understated the refund amount by $3,918 because 10 of 709 services provided had been inadvertently left out of the in initial calculation.

The inability to produce accurate supporting documentation in a timely manner increases the risk of erroneous or inappropriate refunds issued. The County's *Guidelines for Processing a Refund of Collected Revenue* Accounting Technical Bulletin (ATB 20100) requires County agencies that collect revenues determine the validity of the refund amount due to payees and maintain the required documentation to support the refund. Maintaining proper documentation includes retaining reports on file that reconcile with the refund amount being issued, written justifications for issuing the refund, and documented supervisory review and approval.

Recommendation: We recommend CSB maintain adequate supporting documentation on file for all refund payments that is readily available for review. The supporting documentation should agree to the total amount of the refund payments, prior to issuing a refund. The supporting documentation should be subjected to supervisory review and initialed by the preparer and reviewer/approver.

Management Response: CSB will develop a standard methodology and internal business process for calculating and approving refunds due. Management anticipates completing this action by October 1, 2017.