

Internal Audit Department

O R A N G E C O U N T Y
6th Largest County in the USA

INTERNAL CONTROL AUDIT: HEALTH CARE AGENCY MEDICAL BILLING PROCESS

For the Period March 1, 2010
through June 30, 2011

Key Control Audit

Annual Medical Billings
Totaling \$73 Million

Our audit found that internal controls over the Medical Billing Process are adequate to ensure the billings are allowable, valid, and adequately supported. Key controls such as pre-billing and post-payment reviews are in place to help detect incomplete or improper billings. Our audit also found IT application controls over the medical billing process are adequate in the areas of: (1) user access (password and account management), (2) segregation of duties, (3) system edit checks, (4) system enforced holds/queues, and (5) transactional audit trails. Additionally, IT general controls as related to the medical billing systems (IRIS and Practice Expert) are adequate in the areas of: (1) change management, and (2) backup and recovery.

The medical billing process is complex and involves an extensive coordination of efforts between clinics, medical billing, quality assurance, and system personnel. We commend HCA on their established controls and process. During FY 10/11, HCA's annual medical billings totaled \$73 million for services provided under HCA's Behavioral Health, Public Health, and Medical and Institutional Health Services Programs.

We identified **four (4) Control Findings** where HCA should continue efforts to complete business continuity planning documents; consider reducing the extent of its pre-billing and post-payment reviews; and evaluate generating management reports from the IRIS system for monitoring the effectiveness of the medical billing process.

AUDIT NO: 1018
REPORT DATE: DECEMBER 13, 2012

Director: Dr. Peter Hughes, MBA, CPA, CIA
Deputy Director: Eli Littner, CPA, CIA
Senior Audit Manager: Michael Goodwin, CPA, CIA
Senior IT Audit Manager: Autumn McKinney, CPA, CIA, CISA
Audit Manager: Winnie Keung, CPA, CIA
IT Audit Manager: Wilson Crider, CPA, CISA

RISK BASED AUDITING

GAO & IIA Peer Review Compliant – 2001, 2004, 2007, 2010



American Institute of Certified Public Accountants Award to Dr. Peter Hughes as 2010 Outstanding CPA of the Year for Local Government

GRC (Government, Risk & Compliance) Group 2010 Award to IAD as MVP in Risk Management



2009 Association of Certified Fraud Examiners' Hubbard Award to Dr. Peter Hughes for the Most Outstanding Article of the Year – Ethics Pays



2008 Association of Local Government Auditors' Bronze Website Award



2005 Institute of Internal Auditors' Award for Recognition of Commitment to Professional Excellence, Quality, and Outreach

 ORANGE COUNTY BOARD OF SUPERVISORS'
Internal Audit Department

GAO & IIA Peer Review Compliant - 2001, 2004, 2007, 2010

Providing Facts and Perspectives Countywide

RISK BASED AUDITING

Dr. Peter Hughes **Ph.D., MBA, CPA, CCEP, CITP, CIA, CFE, CFF, CGMA**
Director Certified Compliance & Ethics Professional (CCEP)
Certified Information Technology Professional (CITP)
Certified Internal Auditor (CIA)
Certified Fraud Examiner (CFE)
Certified in Financial Forensics (CFF)
Certified Global Management Accountant (CGMA)
E-mail: peter.hughes@iad.ocgov.com

Eli Littner **CPA, CIA, CFE, CFS, CISA**
Deputy Director Certified Fraud Specialist (CFS)
Certified Information Systems Auditor (CISA)

Michael Goodwin **CPA, CIA**
Senior Audit Manager

Alan Marcum **MBA, CPA, CIA, CFE**
Senior Audit Manager

Autumn McKinney **CPA, CIA, CISA, CGFM**
Senior Audit Manager Certified Government Financial Manager (CGFM)

Hall of Finance & Records

12 Civic Center Plaza, Room 232
Santa Ana, CA 92701

Phone: (714) 834-5475

Fax: (714) 834-2880

To access and view audit reports or obtain additional information about the OC Internal Audit Department, visit our website: www.ocgov.com/audit



OC Fraud Hotline (714) 834-3608



Transmittal Letter



Audit No. 1018 December 13, 2012

TO: Mark Refowitz, Director
Health Care Agency

FROM: Dr. Peter Hughes, CPA, Director
Internal Audit Department

SUBJECT: Internal Control Audit: Health Care Agency
Medical Billing Process

We have completed an Internal Control Audit of the Health Care Agency Medical Billing Process for the period March 1, 2010 through June 30, 2011. We performed this audit in accordance with our *FY 2011-12 Audit Plan and Risk Assessment* approved by the Audit Oversight Committee and the Board of Supervisors. Our final report is attached for your review.

Please note we have a structured and rigorous **Follow-Up Audit** process in response to recommendations and suggestions made by the Audit Oversight Committee (AOC) and the Board of Supervisors (BOS). Our **first Follow-Up Audit** will begin at six months from the official release of the report. A copy of all our Follow-Up Audit reports is provided to the BOS as well as to all those individuals indicated on our standard routing distribution list.

The AOC and BOS expect that audit recommendations will typically be implemented within six months and often sooner for significant and higher risk issues. Our **second Follow-Up Audit** will begin at six months from the release of the first Follow-Up Audit report, by which time **all** audit recommendations are expected to be addressed and implemented. At the request of the AOC, we are to bring to their attention any audit recommendations we find still not implemented or mitigated after the second Follow-Up Audit. The AOC requests that such open issues appear on the agenda at their next scheduled meeting for discussion.

We have attached a **Follow-Up Audit Report Form**. Your agency should complete this template as our audit recommendations are implemented. When we perform our first Follow-Up Audit six months from the date of this report, we will need to obtain the completed document to facilitate our review.

Each month I submit an **Audit Status Report** to the BOS where I detail any critical and significant audit findings released in reports during the prior month and the implementation status of audit recommendations as disclosed by our Follow-Up Audits. Accordingly, the results of this audit will be included in a future status report to the BOS.

As always, the Internal Audit Department is available to partner with your staff so that they can successfully implement or mitigate difficult audit recommendations. Please feel free to call me should you wish to discuss any aspect of our audit report or recommendations. Additionally, we will request your department complete a **Customer Survey** of Audit Services. You will receive the survey shortly after the distribution of our final report.

ATTACHMENTS

Other recipients of this report are listed on the **OC Internal Auditor's Report** on page 7.

Table of Contents



***Internal Control Audit: Health Care Agency
Medical Billing Process
Audit No. 1018***

For the Period March 1, 2010 through June 30, 2011

Transmittal Letter	i
OC Internal Auditor's Report	
OBJECTIVES	1
RESULTS	1
BACKGROUND SUMMARY	3
SCOPE AND METHODOLOGY	6
SCOPE EXCLUSIONS	6
Detailed Results, Findings, Recommendations and Management Responses	
Finding No. 1 – Need to Complete Business Continuity Planning Documents (Control Finding)	14
Finding No. 2 – Pre-Billing and Post-Payment Reviews for Behavioral Health Services Claims (Control Finding)	16
Finding No. 3 – Post-Payment Reviews for Public Health Services Claims (Control Finding)	18
Finding No. 4 – Utilization of IRIS Management Reports (Control Finding)	19
ATTACHMENT A: Report Item Classifications	20
ATTACHMENT B: Health Care Agency Management Responses	21
ATTACHMENT C: Detailed Background of Medical Billing Process	24



Audit No. 1018

December 13, 2012

TO: Mark Refowitz, Director
Health Care Agency

FROM: Dr. Peter Hughes, CPA, Director
Internal Audit Department

SUBJECT: Internal Control Audit: Health Care Agency Medical Billing Process

Audit Highlight

We audited the adequacy of manual and system controls over HCA's Medical Billing Process.

During FY 10-11, HCA's **medical billings totaled over \$73 million** for Behavioral Health, Public Health, and Medical and Institutional Health Services provided through County/HCA operated clinics and by contract providers.

The submission of accurate bills for services rendered to Medicare, Medi-Cal, and any other health plan patient is essential and required by law. Legal sanctions can be imposed by State or Federal regulatory entities for improper billings and claims.

Our audit found that HCA has adequate and effective controls to ensure medical billings and claims are allowable, valid, and adequately supported. We identified **four (4) Control Findings** to enhance the existing process and controls.

OBJECTIVES

In accordance with our *FY 2011/2012 Audit Plan and Risk Assessment* approved by the Audit Oversight Committee and Board of Supervisors, we conducted an Internal Control Audit of the Health Care Agency (HCA) Medical Billing Process. Our audit was conducted in conformance with The Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing. The objectives of our audit were to:

1. Evaluate the adequacy of manual and system controls over HCA's medical billing process to ensure the billings are allowable, supported, and valid.
2. Evaluate the adequacy of pre-billing and post-billing reviews that help detect improper or incomplete billings.
3. Evaluate the adequacy of IT application controls over the billing processes in IRIS and Practice Expert systems in the areas of: user access (password and account management), segregation of duties, system edit checks (e.g., data validations), system enforced holds/queues, and transactional audit trails.
4. Evaluate the adequacy of IT general controls over the IRIS and Practice Expert systems in the areas of change management and backup and recovery.
5. Determine if the medical billing processes are efficient and effective (e.g., no duplication of work or backlogs). Included in this objective is an assessment to determine whether HCA can reduce the extent of pre-payment and post-billing reviews on select medical billings.

RESULTS

Objective #1: Our audit found that controls over HCA's medical billing process are adequate to ensure the billings are allowable, supported, and valid. No findings and recommendations were identified.

Objective #2: Our audit found that pre-billing and post-payment reviews are adequate in detecting incomplete or improper billings.

Objective #3: Our audit found IT application controls over the billing processes in the IRIS and Practice Expert systems are adequate in the areas of user access (password and account management), segregation of duties, system edit checks (e.g., data validations), system enforced holds/queues, and transactional audit trails.

Objective #4: Our audit found that IT general controls over the IRIS and Practice Expert systems are adequate in the areas of change management and backup and recovery. We identified **one (1) Control Finding** concerning HCA's business continuity planning.



Objective #5: Our audit found there were no backlogs or duplication of work. We identified **three (3) Control Findings** where HCA can consider reducing the extent of pre-payment and post-billing reviews of Behavioral Health Services and Public Health Services medical billings, and can consider utilizing the IRIS system to generate management reports.

The following table summarizes our findings and recommendations for this audit. See further discussion in the *Detailed Findings, Recommendations and Management Responses* section of this report. See *Attachment A* for a description of Report Item Classifications.

Finding No.	Finding Classification - (see Attachment A)	Finding and Page No. in Audit Report	Recommendation	Concurrence by Management?
1.	Control Finding	<u>Need to Complete Business Continuity Planning Documents</u> - HCA has completed and submitted about 9% of the Business Continuity Plan documents (Phase 1 of 2) to CEO/IT. (Pgs. 14-15)	HCA should make completion of the County's Business Continuity Plan documents a priority.	Yes
2.	Control Finding	<u>Pre-Billing and Post-Payment Reviews for Behavioral Health Services Claims</u> - There is an opportunity to evaluate the extent of pre-billing and post-payment reviews performed on Medicare and Medi-Cal claims due to low error rates. (Pgs. 16-18)	Evaluate pre-billing and post payment review process over Medicare and Medi-Cal claims with consideration of modifying the frequency of reviews and sample sizes.	Yes
3.	Control Finding	<u>Post-Payment Reviews for Public Health Services Claims</u> - There is an opportunity to evaluate the frequency and sample sizes used in the reviews performed on the Family Pact Program. (Pg. 18)	Evaluate post payment review process over PHS claims for Family Pact Program with consideration of modifying the frequency of reviews and sample sizes.	Yes
4.	Control Finding	<u>Utilization of IRIS Management Reports</u> - IRIS contains valuable data and reports that can be used for analytical purposes. However, certain information or reports are not readily available. (Pg.19)	Evaluate the ability to generate IRIS management reports to help monitor and evaluate the processes and controls for behavioral health medical services provided and billed.	Yes



BACKGROUND SUMMARY

(See Detailed Background of Medical Billing Process in Attachment C)

HCA's **Mission Statement:** *Dedicated to protecting and promoting the optimal health of individuals, families, and our diverse communities through partnerships, community leadership, assessment of community needs, planning & policy development, prevention & education, and quality services.* HCA is comprised of the following four service areas:

1. **Behavioral Health Services (BHS)** provides countywide mental health care services and/or alcohol and drug abuse treatment to eligible residents. **During FY 10-11, HCA's BHS billings totaled \$71,026,950 for the year.** This amount includes "self-pay" billings to clients who have a financial obligation to pay for services received. If self-pay invoices are not paid in full, the invoices are included in the subsequent month's billings. **During FY 10-11, HCA received payments totaling \$41,458,134.** These payments, including State Realignment Funds, are received in arrears, so timing differences exist. The majority of BHS claims are billed through Medi-Cal.
2. **Public Health Services (PHS)** monitors the incidence of disease and injury in the community and develops preventive strategies to maintain and improve the health of the public. **During FY 10-11, HCA's billings totaled \$1,849,114 for the year and received payments totaling \$1,852,665.** Timing differences exist between amounts billed and payments received. The majority of PHS claims are billed through Medi-Cal.
3. **Medical and Institutional Health Services (MIHS)** provides emergency care and essential medical services to persons for whom the County, by law, has responsibility for providing such services. **During FY 10-11, HCA's billings totaled \$111,816 and received payments totaling \$59,719.** Timing differences exist between amounts billed and payments received. The majority of MIHS claims are billed through Cal-Optima. We did not include MIHS in our scope due to the low volume of billings.
4. **Financial and Administrative Services** provides internal support to HCA, and includes **HCA Accounting Services**, an Auditor-Controller Satellite Accounting Unit. Within HCA Accounting Services is the **Medical Billing Unit (MBU)**, which provides specialized medical billing services for services provided in County-operated clinics.

Medical Billing Unit

The MBU provides specialized medical billing services and supports HCA by preparing billings and claims for reimbursement for services provided to its clients in County-operated clinics. For BHS, in addition to the County-operated clinics, HCA also uses contractors to provide BHS services. It is important to note that **MBU does not prepare or process any claims for contractor-operated clinics.** The table below shows the service areas provided through HCA/County-operated clinics and contract providers:

	BHS	MIHS	PHS
County-Operated Clinics	For Mental Health Services and for Court-ordered Alcohol & Drug Abuse Services	County employees provide services at Juvenile Hall and Orangewood Children's Home	For Public Health Services
Contract Entities/ Contract Providers	For Mental Health Services and Alcohol & Drug Abuse Services	None	None

BHS Contract Providers

HCA contracts with vendors (contract providers) to provide behavioral health services. These contract providers are responsible for entering their medical billings and claims (generally for Medi-Cal) directly into the County's IRIS system. The contract providers' claims are then submitted to the State for payment in the same electronic file as the County's claims. The County receives payment for the contract providers' claims, but does not pass through payments to them. Instead, HCA pays the contract providers in arrears according to their contract agreement. There are **33 County-operated clinics and 86 contract providers** that provide BHS services on behalf of HCA. We did not include contract providers in the scope of this audit.



As such, HCA has only administrative responsibility over the contractor operated clinics for ensuring services are provided; verifying proper documentation is maintained; ensuring compliance with rules and regulations; and providing training. Neither the County nor HCA have any financial obligations for any non-compliance issues by the contract providers. The contract providers are responsible for:

- Correcting and resubmitting any denied claims that are identified by HCA
- Deducting void claims from future claims (system automatically withholds)
- Refunding any amounts identified during a post payment/billing audit
- Paying any recoupment and/or penalties resulting from a State claim audit
- Submitting Medicare or third party claims directly (not part of County processes or billings)

Medical Billing Information Systems

HCA utilizes three key systems/software to support the medical billings:

1. **IRIS System:** For BHS, HCA uses the Integrated Records Information System (IRIS) to facilitate billings to Medicare, Medi-Cal and other third parties, and reporting to the State of California. IRIS functionality includes: client registration and scheduling, management and reporting of medical tests, reporting the performance and management of billing activities in compliance with State and Federal regulations, and aiding the production and exchange of health care information with external parties in a secure manner. **ProFit** is the billing module of IRIS.
2. **Practice Expert System:** For PHS and MIHS, HCA uses the Practice Expert system for registration, demographic information, reporting, and processing billings.
3. **EDifecs Software:** HCA utilizes EDifecs software to perform HIPAA data validations on the electronic files prior to submitting billings and claims to the State and to Medicare. The State also uses EDifecs to perform its HIPAA data validations.

Overview of Medical Billing Process

The medical billing process starts with the registration/intake of clients through documenting the clinic services provided and submitting electronic billing documents to the State. There are differences in the billing processes and systems for Behavioral Health and Public Health Services as noted below and in the Detailed Background in [Attachment C](#). Below is an overview of steps involved in the medical billing processes for BHS and PHS:

1. Financial Evaluation and Clinic Visits

Registration/Intake: Prior to providing clinic services, the patient meets with a Financial Evaluator who performs a financial evaluation to determine eligibility for various medical reimbursement programs (Medicare, Medi-Cal, CalOptima, etc.) and completes the evaluation in the system, which determines the client's financial responsibility. An UMDAP (Uniform Method for Determining Ability to Pay) form is produced from the system for the client to sign up for BHS services. The patient is registered and the financial information is entered into the applicable system (IRIS or Practice Expert).

Encounters: Each time a patient visits a clinic where a clinician provides services/treatments, this is known as an encounter. A Progress Note and Encounter Document (ED) are completed to document services/treatments and to support the medical billing.

Data Entry: Encounters are entered into the applicable system based on the EDs. The systems perform data validations as the information is being entered for BHS only.

2. Pre-Billing Reviews

Onsite pre-billing reviews are performed to ensure claims are accurate, complete, and valid/supported prior to submission as follows:



- All BHS Medicare and Medi-Cal claims go through a pre-billing review to ensure completeness and accuracy prior to submission. These claims are electronically routed in IRIS. IRIS has various 'Hold' statuses, which indicates a specific review is needed (e.g., **Coder Holds**, **QIPC Holds** and **MRT Holds**). Upon passing the pre-billing review, the electronic hold is released by the reviewer.
- PHS claims, excluding Family Planning Access Care and Treatment Program (see Post-Billing Reviews at #6 below) are selected to go through pre-billing reviews on a sample basis. PHS claims are processed in Practice Expert. Practice Expert does not have any system enforced or electronic "Holds." The pre-billing review occurs prior to entering the billing information into Practice Expert.

3. Submission of Billings to Claims Processor

Claims for BHS services are generated by the applicable system after going through a series of system edits to validate the claim. Claims are generated as electronic claims. Medicare and Medi-Cal claims are batched into an electronic 837 file on a weekly basis for BHS or on a daily basis for PHS. The 837 file is what is sent to the State or to Medicare by HCA, and is validated against HIPAA standards and Medi-Cal's local edits by the EDifecs software prior to being transmitted to the claim processor. The file/claim will either be accepted or rejected by the EDifecs software. Paper CMS-1500 claims are created for third party healthcare plans and mailed to the insurance carrier.

- **Accepted Claims.** File passes the edit checks and will be adjudicated (accepted) by the State or by Medicare.
- **Rejected Claims.** A rejected status is not a final adjudication for a claim. The State or Medicare returns the entire 837 file/claim to HCA, where it will be researched for correction and resubmission.

4. Adjudication of Claims – Approval or Denial

Once BHS claims are adjudicated, an 835 batch file (the 835 file is created after the State or Medicare's review) is downloaded into the IRIS/ProFit module and includes the following:

- **Approved Claims.** Approved claim payments are posted into the corresponding IRIS account.
- **Denied Claims.** A denied status is a final adjudication for a specific claim. The denied Medicare or Medi-Cal claim will be automatically placed in the Technical Denial work queue for correction and rebilling. The denied claim can be appealed by submitting a corrected claim. Denials for other healthcare plans are processed manually.

Adjudicated claims for PHS and MIHS are downloaded and recorded into Practice Expert.

5. Payment to HCA

HCA receives payment for all claims submitted, including contractor-operated clinics.

6. Post-Billing Reviews

Onsite post-billing reviews are performed to identify inaccurate or incomplete paid claims and determine if the claim needs to be credited or refunded.

- **BHS:** All BHS Medicare paid claims have a post-billing review. Paid BHS Medi-Cal claims for Children and Youth Services go through a post-billing review on a sample basis. BHS Medi-Cal Adult Mental Health Service paid claims do not go through a post-billing review.
- **PHS:** In general, PHS claims have pre-billing reviews; therefore, post billing reviews are not performed. MBU does conduct post-payment reviews on the Family Planning Access Care and Treatment (FPACT) Program on a sample basis as it does not go through a pre-billing review.



SCOPE AND METHODOLOGY

Our audit evaluated internal controls and processes over selected aspects of the medical billing process for the period March 1, 2010 through June 30, 2011. Our methodology included inquiry, auditor observation, and testing of relevant documents over the following:

1. Evaluation of manual and system controls and processes over medical billings initiated at the County-operated clinics to ensure medical claims are allowable, valid, and adequately supported.
2. Evaluation of controls over pre-billing reviews at: a) HCA's Medical Billing Unit (MBU) for BHS Medicare claims and PHS Medi-Cal claims, and b) Quality Improvement & Program Compliance (QIPC) for BHS Medi-Cal claims to ensure medical claims are allowable, valid, and adequately supported.
3. Evaluation of controls over post-billing/payment process at QIPC for BHS Medi-Cal claims and at MBU for BHS Medi-Cal and PHS Medi-Cal claims.
4. Evaluation of IT Application Controls (IRIS and Practice Expert) over user access (password and account management), segregation of duties, system edit checks (e.g., data validations), system holds/queues, and transactional audit trails.
5. Evaluation of IT General Controls related to the medical billing systems (IRIS and Practice Expert) in the areas of change management and backup and recovery.

SCOPE EXCLUSIONS

Our audit did not include a review of the following:

- Billing and claims for Medical and Institutional Health Services (MIHS).
- Billing and claims submitted to third-party health plans, including Denti-Cal and Cal-Optima.
- Billings and claims for services provided by contract providers (non-par).
- IT general controls in the areas of IT administration/strategic planning; physical security (since servers were moved from HCA to the OC Data Center); and security administration. We did not perform an IT audit of HCA as a whole.
- IT application controls reviewed were limited to those medical billing objectives covered by the audit scope. We did not perform a comprehensive application review of IRIS or Practice Expert as a whole.
- Compliance with HIPAA or other privacy laws.
- Compliance with billing rules and regulations established by Medicare and Medi-Cal.
- Patient's eligibility for medical benefits.
- Controls over cash receipts and accounts receivable/collections pertaining to medical billings.
- Controls over cost reimbursement for medical services funded by grants and State allocations.

Management's Responsibilities for Internal Controls

In accordance with the Auditor-Controller's County Accounting Manual Section S-2 *Internal Control Systems*: "All County departments/agencies shall maintain effective internal control systems as an integral part of their management practices. This is because management has primary responsibility for establishing and maintaining the internal control system. All levels of management must be involved in assessing and strengthening internal controls." Control systems shall be continuously evaluated by Management and weaknesses, when detected, must be promptly corrected. The criteria for evaluating an entity's internal control structure is the Committee of Sponsoring Organizations (COSO) control framework. Our Internal Control Audit enhances and complements, but does not substitute for, HCA and HCA Accounting's continuing emphasis on control activities and self-assessment of control risks.

Inherent Limitations in Any System of Internal Control

Because of inherent limitations in any system of internal controls, errors or irregularities may nevertheless occur and not be detected. Specific examples of limitations include, but are not limited to, resource constraints, unintentional errors, management override, circumvention by collusion, and poor judgment. Also, projection of any evaluation of the system to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or the degree of compliance with the procedures may deteriorate. Accordingly, our audit would not necessarily disclose all weaknesses in the HCA's or HCA Accounting's operating procedures, accounting practices, and compliance with County policy.



Acknowledgment

We appreciate the courtesy extended to us by the Health Care Agency and HCA Accounting Services' personnel during our audit. If we can be of further assistance, please contact me directly at 834-5475 or Michael Goodwin, Senior Audit Manager at 834-6066.

Attachments

Distribution Pursuant to Audit Oversight Committee Procedure No. 1:

Members, Board of Supervisors
Members, Audit Oversight Committee
Robert J. Franz, Interim County Executive Officer
Steven Eldred, Interim Deputy CEO, Government and Public Services
Jeff Nagel, Ph.D., Deputy Agency Director, Finance/Administrative Services, HCA
Jan Grimes, Chief Deputy Auditor-Controller
Kimberly Engelby, Manager, HCA Accounting Services
Leslie Sorrells, Manager, Medical Billing Unit, HCA
Teri Schultz, Chief Information Officer, HCA
Adil Siddiqui, IRIS Director, HCA/Information Technology
John Moore, IRIS Operations Manager, HCA/Information Technology
Doug Phan, Manager, HCA/Information Technology
Thea Bullock, Chief Compliance and Privacy Officer, HCA
David Horner, Division Manager, Quality Improvement and Program Compliance, HCA
Foreperson, Grand Jury
Susan Novak, Clerk of the Board of Supervisors

Detailed Results, Findings, Recommendations and Management Responses



Objective #1: Evaluate the adequacy of manual and system controls over HCA's medical billing process to ensure the billings are allowable, supported, and valid.

Work Performed

We performed the following to accomplish our audit objective:

1. Obtained and reviewed HCA Behavioral Health Services and Medical Billing Unit's Operating Policies and Procedures pertaining to the medical billing process.
2. Obtained a detailed understanding of medical billing process and controls for Behavioral Health Services and Public Health Services, starting with patient registration, patient visits/encounters, pre-billing reviews, submission of claims to the State, and post-payment reviews.
3. Obtained reports of total monthly billings and claims submitted, and payments received for Fiscal Years 2009-10 and 2010-11 for each of the above divisions.
4. Conducted meetings with HCA management to obtain an understanding of their roles and responsibilities over medical billing, including Medical Billing Unit, Quality Improvement & Program Compliance, and Claims and Financial Reporting.
5. Conducted meetings with HCA Division Program Managers and HCA/Information Technology concerning their roles in the medical billing process.
6. Performed site visits at four HCA clinics (17th Street Clinic, Santa Ana Clinic, Costa Mesa Clinic, and Children & Youth Services at the Manchester Office Building). At the clinic, we conducted interviews, performed walkthroughs, and observed the processing and inputting patient's registration, encounter and billing information, observed pre-billing and/or post-billing payment reviews of Medi-Cal and Medicare BHS & PHS claims.
7. Observed the processing of billings and claims in IRIS (ProFit billing module) and Practice Expert at the clinics and in the Medical Billing Unit.
8. Reviewed documents and reports generated from IRIS to understand how the system is used in the medical billing process, including the various work queues and system holds.
9. Obtained an understanding of the medical billing submission process and reviewed related documents showing the denial and repayment of claims.
10. Obtained an understanding of the re-billing process when claims are rejected or denied.

Conclusion

Based on our audit, we found manual and system controls over medical billing processes for Medi-Cal and Medicare claims are adequate and effective to ensure billings and claims for reimbursement are allowable, supported, and valid. Key controls that we identified under this objective include:

1. An extensive quality assurance process is in place that is achieved through the pre-billing and post payment audits performed for BHS & PHS claims to ensure they are valid, complete, and accurate prior to submission for payment.
2. The quality assurance process includes re-verifying the client's program eligibility (for Medicare, Medi-Cal, etc.) that is determined during initial intake and registration for BHS only. This helps to ensure continued eligibility for reimbursement prior to submitting claims for payment.



3. The quality assurance process ensures that claims are adequately supported by documents such as patient charts, clinic notes, and other documentation of medical services provided. Any inaccurate or incomplete claims that do not have the necessary supporting documentation are identified and resolved before being submitted for payment.
4. There are work queues and system holds in place that require reviews to be conducted before billings are submitted. These reviews include medical team chart reviews, coding reviews, and for quality assurance. Explanations are documented when claims are put on hold and not approved.
5. When errors, inaccurate claims or unsupported claims are detected in the pre-billing reviews, the documentation is returned to the clinic/health care provider for correction and resubmission of the billing. Re-billings go through the same work queues, holds, and reviews as the original billings.
6. HCA has adopted a conservative approach in medical billing, and if there is any indication that a claim is improper, incomplete or inaccurate, it does not get submitted to the State for reimbursement. HCA will attempt to correct the billing issue in order to re-bill, but will not submit any billings or claims when there is a possibility that the claim could be rejected or denied.

Our audit found that HCA's medical billing process is complex and involves an extensive coordination of effort between HCA clinics, the Medical Billing Unit, Quality Improvement and Program Compliance (QIPC), Administration, and Information System personnel. We commend HCA on the controls and processes they established over the medical billing process to ensure the billings are allowable, supported, and valid.

As such, we have no findings and recommendations under this objective.



Objective #2: Evaluate the adequacy of pre-billing and post-billing reviews that help detect improper or incomplete billings.

Work Performed

We performed the following to accomplish our audit objective:

1. Obtained a detailed understanding of the pre-billing review process for billings and claims submitted from Behavioral Health Services and Public Health Services. This included an evaluation of the frequency of reviews and sample sizes.
2. Conducted walkthroughs, interviews, and reviews of related documentation at a sample of HCA clinics, to validate the pre-billing reviews and post-billing payment reviews performed by QIPC and MBU.
3. Evaluated processes for conducting Clinic Technical Reviews and Medical Review Teams Chart Reviews for Medi-Cal claims to determine if they are valid and supported in clinic documents.
4. Obtained an understanding of work queues and holds in IRIS that requires reviews/approvals before Medi-Cal and Medicare claims are submitted for payment.
5. Obtained and reviewed system billing reports that document the medical billing process work-flow, results, and statistical data or metrics.
6. Obtained an understanding of the technical requirements, certifications and training needed by the Medical Review Teams in Quality Improvement and Program Compliance, and by the Medical Billing Unit Coders to conduct pre-billing and post-billing payment reviews.

Conclusion

Our audit found that pre-billing and post-payment reviews are adequate in helping to detect and prevent improper or incomplete billings. The level of pre-billing and post-payment reviews is determined by HCA based on the program and reimbursing entity. Key controls noted under this objective included:

1. Automatic billing holds in IRIS that prompt for various pre-billing reviews [e.g., chart reviews (MRT Holds) and coder reviews (Coder Holds)]. These reviews are vital in helping to detect errors, omissions, improper coding, and non-compliance prior to submitting Medicare and Medi-Cal billings and claims for payment. The reviews also help ensure claims are adequately supported.
2. A quality assurance process that re-verifies patients' Medicare eligibility and that prior holds have been passed. For certain HCA programs where Medi-Cal is billed (e.g., Children & Youth Services), there are pre-billing reviews using Medi-Cal Review teams (MRT) in QIPC and Clinic Technical Reviews at the clinic sites.
3. Post-payment reviews are done on selected paid claims to ensure they are accurate and supported. Also, post-payment reviews analyze claim errors and use this information as a basis for additional training to prevent similar errors from occurring. Currently, post-payment reviews reflect an error rate below 5% (the industry standard acceptable error rate is 5%).

There are no findings and recommendations for this objective. See [Audit Objective #5](#) regarding efficiency and effectiveness of pre-billing and post-payment reviews.



Objective #3: Evaluate the adequacy of IT application controls over the billing processes in the IRIS and Practice Expert systems in the areas of user access (password and account management), segregation of duties, system edit checks (e.g., data validations), system enforced holds/queues, and transactional audit trails.

Work Performed

We performed the following to accomplish our audit objective:

1. Gained an understanding of procedures for granting users access to the applications to determine whether: only department management has the authority to add or modify access rights; authorization is in written form or communicated via email; and email authorizations or written authorizations are filed.
2. Gained an understanding of procedures for removing user access upon employee transfer or termination to determine whether: security administration is notified promptly in writing or verbally with written follow-up when an employee gives notice or is to be terminated; notification includes employee's last day of employment; and upon notification, the security administrator immediately deactivates or removes the user account or user profile from the system.
3. Obtained application account and password settings for the following parameters to determine whether they meet best practices: minimum password length; number of days before system forces system password change; number of times password must be changed before a password may be reused; number of concurrent connections allowed; number of incorrect logon attempts before the account is locked; length of lock out period (users should be required to contact an appropriate individual to remove account lock), and length of time incorrect logon count is retained.
4. Obtained a listing of application users and reviewed access for an appropriate segregation of duties (data entry versus review/release) and access to confidential data as related to the billing process.
5. Conducted walkthroughs, interviews, and reviews of related documentation at a sample of HCA clinics, the Quality Improvement and Program Compliance Division, and the Medical Billing Unit to obtain a detailed understanding of medical billing processes and controls for Behavioral Health Services and Public Health Services, starting with patient registration, patient visits/encounters, pre-billing reviews, submission of claims to the State, and post-payment reviews. The purpose was to document application edit checks (e.g., duplicate claims, valid diagnostic and procedure codes, etc.) and transactional audit trails (data logged – user, date/time, actions taken, data values before/after and events logged - data changes, reviews/approvals, etc.).

Conclusion

Our audit found IT application controls over the billing process in the IRIS and Practice Expert systems are adequate in the areas of user access (password and account management), segregation of duties, system edit checks, system enforced holds/queues, and transactional audit trails. Key controls noted were:

1. Based on discussions with relevant HCA staff and review of forms, procedures for granting users access to the applications included the following: only department management has the authority to add or modify access rights; authorization is in written form or communicated via email; and email authorizations or written authorizations are filed.



2. Based on discussions with relevant HCA staff and review of forms, procedures for removing user access upon employee transfer or termination included the following: security administration is notified in writing or verbally with written follow-up when an employee gives notice or is to be terminated; notification includes employee's last day of employment; and upon notification, the security administrator will deactivate or remove the user account or user profile from the system.
3. HCA uses the departmental network account and password security settings to restrict access to the applications (IRIS and Practice Expert). For the network account settings, we reviewed those settings and determined the following settings were appropriate: number of concurrent connections allowed, number of incorrect logon attempts before the account is locked, length of lock out period (users should be required to contact an appropriate individual to remove account lock), and length of time incorrect logon count is retained. For the password security settings, we reviewed and determined the following settings were appropriate: minimum password length, number of days before system forces system password changes, number of times password must be changed before a password may be reused.
4. IRIS and Practice Expert application user access for the billing process is appropriate including adequate segregation of duties (data entry versus review/release) and access to confidential data.
5. IRIS application controls for the billing process included: assigned user profiles limiting their access and capabilities, users are only allowed to view/edit data for their assigned organizations, system enforced billing holds (each hold has to be cleared before it can be billed), validation of diagnosis and procedure codes, billing rates are calculated by the application based on the diagnosis/procedure codes, and valid Medical Record Number and FIN (unique encounter/visit identifier) required.
6. IRIS application audit trails for the billing process includes comments/notes section containing system generated entries for activity (data logged – user, date/time, actions taken; events logged - data changes, reviews/approvals, hold releases). The comments/notes cannot be deleted or modified by the end users, only added to.
7. Practice Expert application controls for the billing process included: assigned user profiles limiting their access and capabilities, valid diagnosis/procedure codes, and billing rates calculated by the application based on the diagnostic/procedure codes.
8. Practice Expert application audit trails for the billing process consisted of system generated entries (user name and date) for charge entry and charge modification.

There are no findings or recommendations for this objective.



Objective #4: Evaluate the adequacy of IT general controls over the IRIS and Practice Expert systems in the areas of change management and backup and recovery.

Work Performed

We performed the following to accomplish our audit objective:

1. Obtained and reviewed HCA's written procedures for modifying the IRIS and Practice Expert application software including patches and maintenance to determine whether the procedures were adequate. HCA does not modify the IRIS or Practice Expert application code. Any code changes are submitted to the respective vendor for consideration. For IRIS only, HCA does perform configuration modifications (such as adding a new contract service provider) to process billings. These change requests are handled internally per HCA policy.
2. Obtained and reviewed software agreements for IRIS and Practice Expert to determine whether they address: vendor support; procedures for requesting systems software enhancements; software fixes and enhancements are provided in a timely manner; and product training.
3. Obtained and reviewed samples of IRIS change request documentation to determine whether it addresses the following: documentation is provided with the fixes from the vendor; documentation provided by the vendor is clear and easy to use; installation documentation is provided by the vendor; and operations documentation is provided by the vendor.
4. Obtained and reviewed written backup and recovery procedures to determine whether they were adequate.
5. Determined whether disks are configured to ensure that a single disk problem does not bring the entire system down.
6. Obtained and reviewed the County Business Continuity Plan Component Deliverables Status Tracking report from CEO/Information Technology to determine whether HCA is actively participating in the County's business continuity planning project and their status.

Conclusion

Our audit found that IT general controls are adequate in the areas of change management and data backup and recovery for the IRIS and Practice Expert application software. Key controls noted were:

1. HCA has written procedures for updating the IRIS and Practice Expert application software. HCA does not change the underlying application code for IRIS and Practice Expert and instead change requests are sent to the vendor. The application update procedures include:
 - Change requests are managed using the vendor's support web site (IRIS only).
 - Software updates received from the vendor are reviewed by knowledgeable individuals.
 - Adequate testing of the software updates is conducted prior to implementation.
 - End users are involved in the testing.
 - Only appropriate patches/upgrades are selected for implementation.
 - Software is implemented during times when processing is slow or non-existent.
 - The implementation of new software products is communicated to all affected areas of HCA.
 - Implementation tasks are clearly defined and responsibilities are assigned.
 - Documented back-out procedures are developed and available if problems occur during implementation.
 - Affected systems are backed up before fixes are applied.
 - A post implementation review is performed.



Additionally, for IRIS only, HCA performs configuration modifications (such as adding a new contract service provider) for the billing process. This is a relatively complex process due to certain limitations of the IRIS application (hospital vs. clinic environment). HCA follows similar steps as the application updates noted above. As these are internal modifications, HCA uses a standardized request form and logs the requests.

2. Software agreements for IRIS and Practice Expert address the following: vendor support has been clearly defined; procedures for requesting systems software enhancements are clear and straightforward; and software fixes and enhancements are provided in a timely manner.
3. Software documentation for IRIS and Practice Expert addresses the following: documentation is provided with the fixes from the vendor; documentation provided by the vendor is clear and easy to use; installation documentation is provided by the vendor; and operations documentation is provided by the vendor.
4. Backup and recovery written procedures include the following: backups are taken regularly; backup tapes are periodically write tested to ensure that they can be utilized if required; the backup scheme allows the system to be restored to within 24 hours of the incident; on-site backup tapes are stored in secured, locked and fireproof facilities; off-site backup tapes are stored in secured, locked and fireproof facilities; backup tapes are rotated between on-site and off-site storage facilities; and recovery procedures are documented and are tested periodically.
5. The storage devices are configured to ensure that a single disk problem does not bring the entire system (IRIS and Practice Expert) down.
6. HCA is participating in the County's business continuity planning project; however, HCA has only submitted 9% of the requested documents for Phase One. See [Finding No. 1](#) below.

Under this objective, we identified **one (1) Control Finding** concerning HCA's business continuity planning. Our finding and recommendation is noted below:

Finding No. 1 – Need to Complete Business Continuity Planning Documents

Summary

As of July 23, 2012, HCA has completed and submitted to CEO/IT about 9% of the County's Business Continuity Fundamental Plan Components documents for Phase One. **(Control Finding)**

Details

A current and effective business continuity plan is necessary to ensure continued operations in the event of a disaster. To this end, the County created the County of Orange Business Continuity Program and tasked the CEO/IT with managing this effort. CEO/IT divided the task into two phases: (1) business impact analysis and development of business continuity plan documents, and (2) testing of the plan documents and on-going maintenance of the plan documents. Currently, CEO/IT is coordinating with the County departments to complete the Phase One - Business Continuity Fundamental Plan Components (completion target was end of 2011) and to transition County departments into Phase Two - testing of the plan documents. As part of managing the project, CEO/IT purchased software to assist with the development of the documentation including the PrepareOC and RecoverOC web portals and templates and samples for the Business Continuity Fundamental Plan Components.

Detailed Results, Findings, Recommendations and Management Responses



As of July 23, 2012, HCA has completed and submitted about 9% of the Business Continuity Fundamental Plan Components documents to CEO/IT. The HCA status is:

CEO/IT has received the following from HCA:

- Critical Business Process Listing (incomplete)
- Critical Process IT Dependency (complete)
- Critical Business Process IT Dependency Recovery Strategies Identification (incomplete)

The following documents have not been submitted by HCA:

- Delegations of Authority
- Orders of Succession
- RACI (Responsible, Accountable, Consulted, Informed) and Team Responsibilities/Detail
- Logistics Tables (such as Alternate Facilities, IT Dependencies, Vital Records, Workforce Planning, and Vendors and Supporting Departments)
- Communication Tables
- Critical Business Process Continuity Strategy Identification
- Incident Response Workflow/Decision Matrix
- Incident Response Checklist

The absence of these documents may impede HCA from continuing/resuming normal business operations in an effective and timely manner in the event of a disaster. HCA's delays appear to be due to the complexity of its environment and the numerous programs which it has to coordinate and other resource commitments to prepare a consolidated business continuity document.

Recommendation No. 1

HCA continue to participate with the Countywide Business Continuity planning project and make it a priority to complete and submit the Business Continuity Fundamental Plan Components documents (Phase One).

Health Care Agency Management Response

Concur. HCA is aware of the importance of the Business Continuity Fundamental Plan and has already made this a high priority. Since the completion of the audit review, HCA IT has made significant progress and has submitted additional documentation to CEO IT increasing the completion percentage from about 9% to over 72%.



Objective #5: Determine if the medical billing processes are efficient and effective (e.g., no duplication of work or backlogs). Included in this objective is an assessment to determine whether HCA can reduce the extent of pre-payment and post-billing reviews on select medical billings.

Work Performed

We performed the following to accomplish our audit objective:

1. Inquiry of management and staff responsible for providing medical services and medical billing, including site visits at four County-operated clinics, the Medical Billing Unit, and HCA's Quality Improvement and Program Compliance (QIPC) Division.
2. Auditor observations and walkthroughs of the medical billing process, starting with patient intake/registration, patient visits/encounters, inputting transactions into IRIS and Practice Expert, and billing processes in the Medical Billing Unit.
3. Observation and inquiry for evidence of backlogs and duplication of work.
4. Assessed HCA's methodologies (e.g., frequency, sample sizes) over pre-billing and post-payment reviews to determine if they can be modified. We performed this assessment at the request of HCA management to evaluate whether the 100% sample size of the reviews were still necessary given that the Integrity Agreement with the Office of the Inspector General has ended.

Conclusion

Our audit found there were no significant backlogs or duplication of work in the areas under audit. We assessed HCA's methodology and controls over pre-billing and post-payment reviews, and identified **three (3) Control Findings** where HCA can modify its controls in conducting pre-payment and post-billing reviews of select types of medical billings, and evaluate the ability for IRIS to generate management reports. Our three findings and recommendations are noted below:

Finding No. 2 – Pre-Billing and Post-Payment Reviews for Behavioral Health Services Claims

Summary

Since the Integrity Agreement between HCA and the Office of the Inspector General ended in December 2010, HCA continues to perform extensive pre-billing and post-payment reviews on Medi-Cal and Medicare claims. There is an opportunity to re-evaluate performing these extensive reviews because HCA's current billing error rate is less than 1%, which is under the industry standard of 5%. **(Control Finding)**

Details

According to HCA, billing for Medicare Behavioral Health Services is unique and particular in documenting services performed and applicable coding. When HCA began billing for Medicare services in 1990s, they erroneously used the same billing code for Medi-Cal and/or Medicare services, which resulted in inadvertent overbilling. In 2000, Federal Government noted the billing issue and notified HCA of the concern; however the issue did not get immediately addressed and continued in subsequent billings. Then the Federal Government conducted an investigation on paid claims for previous years. The investigation identified billing errors and resulted in litigation. A settlement was reached in 2007, resulting in HCA paying \$7 million as settlement. In addition, HCA entered an Integrity Agreement with the Office of Inspector General for three years, effective December 2007 through December 2010.

Detailed Results, Findings, Recommendations and Management Responses



Under the Integrity Agreement, HCA performed pre-billing reviews on 100% of the Medicare and Medi-Cal claims and post-payment audits on all Medicare claims to ensure they were proper and adequately supported. (Note: Although the errors resulted from Medicare claims, the Office of Inspector General determined that Medi-Cal claims should also be included in the Integrity Agreement as both are funded by the Federal government.)

To strengthen internal controls and ensure compliance, HCA established the Office of Compliance, recruited Certified Coders to perform billing reviews, and adopted a more conservative billing practice to reduce risk and to ensure billing errors are within the industry standard. Because of the extensive billing review process, the current External Quality Review showed HCA's error rate was **less than 1%**. In June 2011, HCA received a letter from Office of Inspector General officially indicating the term of the Integrity Agreement had ended. However, HCA continued its conservative approach by conducting pre-billing and post payment reviews of all Medicare claims at different levels (e.g. MRT Chart Review, Charge Audit Review, MBU Coder Review, and a QIPC Review) because of the fiscal impact of billing errors on the County.

Now with the Integrity Agreement ended, HCA has an opportunity to modify its pre-billing and post payment review processes. HCA should evaluate the pre-billing and post-payment review processes for consideration of the following:

1) System Holds for Processing Medi-Medi Claims

HCA may want to assess the risk of removing the MRT hold for Medi-Medi Claims. Patients/clients eligible for both Medicare and Medi-Cal are referred as Medi-Medi. These claims are submitted to both Medicare (primary) and Medi-Cal (Secondary) for Behavioral Health Service provided. Currently, there are built-in system holds in IRIS to ensure all claims are reviewed prior to submitting them for reimbursement. All holds have to be cleared by the reviewer before the claim is submitted to the State for adjudication. Therefore, Medi-Medi claims require not only a MBU Coder Review, known as Coder Hold, but also a Quality Improvement & Program Compliance Chart Review, known as MRT Hold. Although the objectives of these reviews are different, we noted that the Coder Review makes the final determination whether or not the billings can be submitted in the event there are conflicts between these two reviews. Since the Coder Review supersedes Chart Review, HCA should consider the necessity of the MRT hold for these claims.

2) Conducting Pre-Billing and Post Payment Reviews on a Sample Basis

Currently, there are three Certified Coders conducting pre-billing and post payment reviews on all Medicare claims prior to submitting them for billing. Because of the enhanced pre-billing review, the error rate was less than the industry standard. HCA should assess conducting reviews based on a designated sample size, or consider conducting either a pre-billing or post payment review on Medicare claims, but not perform both reviews on the same claim.

Recommendation No. 2

HCA evaluate its pre-billing review process for Medi-Medi Claims and determine the need to continue the current process which requires both reviews at MBU and QIPC. In addition, HCA should evaluate its pre-billing and post payment review process for Behavioral Health Services Medicare claims with consideration of frequency and sample sizes of the reviews given they are below the industry standard in the number of errors identified.

Health Care Agency Management Response

Concur. During the course of this audit, the role of QIPC and MBU in the review process was analyzed and changes have already been implemented. The pre-billing review process for all Medi-Medi Claims has been modified to include only the MBU Coder review. QIPC now completes post-payment reviews on a sample basis. HCA will continue to review 100% of Medicare claims due to the conservative approach of the agency.



The post-billing review process has also been analyzed and will be adjusted to reflect the low error rate. However, as significant or critical changes occur in the billing process, such as will happen in January 2013, 100% of Medicare services will be reviewed post-payment. When it is found that the error rate is consistently at 2% or less, the post-payment review process will be modified to a sample size of about 20%. However, if the error rate at any time increases above 2%, the sample size for that program will be adjusted accordingly. In addition, if the error rate remains at or below 2% for six months, the sample size will again be decreased to about 10%.

Finding No. 3 – Post-Payment Reviews for Public Health Services Claims

Summary

The Medical Billing Unit (MBU) performs post payment reviews for one Public Health Service program ~ Family Pact Program (FPACT). MBU Coders perform post payment reviews on 20% of the FPACT claims. Currently, there are three coders within the MBU and one coder is primarily responsible for performing these reviews on a quarterly basis. We were informed that the post-payment review is behind schedule. The last review conducted in October 2011 was for payments received from January 1, 2011 through March 31, 2011. **(Control Finding)**

Details

During our audit, we observed that the MBU Coder uses a sampling program to select a 20% sample of all patients from the paid report, known as Charges-Payment Profile Report, from Practice Expert. Claims pertaining to the selected patient are reviewed. Since a patient might have multiple claims, this results with the review percentage being more than 20%. Also, there is a risk that the sampling methodology may result with an uncontrollable sample size and thus affect the effectiveness of the review. Our observation was conducted in October 2011 and noted that Coder was reviewing payments for the period for January 1, 2011 through March 31, 2011. The timeliness of the review could be improved if the sample size is controllable at a reasonable percentage.

There are three coders at MBU responsible for conducting pre-billing and post-payment reviews for all BHS Medicare claims and a sample of PHS Medi-Cal claims to ensure they are accurate and adequately supported. An evaluation of the current post-payment review process for PHS claims should be conducted to determine if revision is needed to limit the sample size at a reasonable amount to enhance effectiveness. When we notified the MBU of this finding during our fieldwork, they took corrective action to modify the post-payment review process.

Recommendation No. 3

HCA continue to evaluate the current post-payment review process for PHS claims to determine if revision is needed to limit the sample size at a reasonable amount to enhance effectiveness and efficiency of the post-payment reviews.

Health Care Agency Management Response

Concur. The post-payment review process for PHS claims has been modified as of April 2011 to include a reduction in the sample size for Family Pact from 20% to 10%. This will continuously be monitored and at any time the error rate shows a steady increase above the standard rate of 2%, the sample size will be adjusted accordingly. In addition, the process to determine the samples has been moved from the staff responsible for the review to the MBU IT Systems Technician who has no post-payment responsibilities. This has ensured the staff responsible for the post-payment reviews focus on their core responsibilities allowing for all reviews to be completed on a quarterly basis.



Finding No. 4 – Utilization of IRIS Management Reports

Summary

Our audit noted that IRIS contains information on behavioral health medical services provided and related billings, and that certain management reports can be generated from the system; however, the information is not always readily available and requires additional resources to generate IRIS management reports. **(Control Finding)**

Details

HCA uses IRIS to capture behavioral health services provided to patients and facilitates the billing of claims to Medi-Cal and Medicare. Because IRIS contains both service and billing information, valuable data and reports can be generated for analytical purposes and to monitor the effectiveness of controls over the services and billing process.

For example, some claims might not be processed within the required billing period due to resources or other factors. (Note: Medi-Cal claims are required to be submitted six months from the month of service; and Medicare claims allow 12 months from the date of service). If claims are not submitted within the required timeframe, the County will not get reimbursed and results in loss of revenue. During the audit we requested information on the number of claims that were not submitted due to timeliness. We were informed the data was not readily available and would require additional resources to generate the report.

Examples of other reports that would be useful as a management tool include:

- Claims that missed required billing deadlines.
- Services not billed due to lack of adequate support.
- Non-reimbursable services provided.

Having the system produce reports to help HCA monitor the effectiveness of their processes and controls can be an effective management tool, particularly if there are changes made in the pre-billing, post-payment and quality assurance reviews as discussed above. In order to maximize resources and continue to ensure claims are processed timely and accurately, the Medical Billing Unit and QIPC should consider partnering with IRIS system team to determine the capability of IRIS for generating management reports as a means to monitor the effectiveness of the billing processes.

Recommendation No. 4

HCA determine the capability of IRIS for generating other management reports to assist management in monitoring the effectiveness of processes and controls for Behavioral Health Services provided and billed.

Health Care Agency Management Response

Concur. In January 2010, there was a significant national upgrade to the Electronic Data Interchange standard. The new standard caused a complete re-design of the state's Medi-Cal adjudication system, which was not complete and stable until mid-2012, after the fieldwork was completed for this audit.

Under the former standard, the IRIS team developed reports to help monitor and evaluate the processes and controls for behavioral health services provided and billed. With the implementation of the new standard, these reports needed to be modified and/or re-designed based on newly formatted information provided by the State. The audit occurred during the transition time and certain reports were unavailable. The IRIS management reports have since been modified and are currently in production.




ATTACHMENT A: Report Item Classifications

For purposes of reporting our audit observations and recommendations, we will classify audit report items into three distinct categories:

- ▶ **Critical Control Weaknesses:**
Audit findings or a combination of Significant Control Weaknesses that represent serious exceptions to the audit objective(s), policy and/or business goals. Management is expected to address Critical Control Weaknesses brought to their attention immediately.
- ▶ **Significant Control Weaknesses:**
Audit findings or a combination of Control Findings that represent a significant deficiency in the design or operation of internal controls. Significant Control Weaknesses require prompt corrective actions.
- ▶ **Control Findings:**
Audit findings concerning internal controls, compliance issues, or efficiency/effectiveness issues that require management's corrective action to implement or enhance processes and internal controls. Control Findings are expected to be addressed within our follow-up process of six months, but no later than twelve months.



ATTACHMENT B: Health Care Agency Management Responses



*Excellence
Integrity
Service*

**COUNTY OF ORANGE
HEALTH CARE AGENCY**

OFFICE OF THE DIRECTOR

MARK A. REFOWITZ
DIRECTOR

MAILING ADDRESS:
405 W. 6TH STREET, 7TH FLOOR
SANTA ANA, CA 92701

TELEPHONE: (714) 834-8021
FAX: (714) 834-5506
E-MAIL: mrefowitz@ochca.com

December 7, 2012

TO: Dr. Peter Hughes, CPA, Director
Internal Audit Department

SUBJECT: Internal Control Audit: Health Care Agency
Medical Billing Process - Responses

RECEIVED
INTERNAL AUDIT DEPARTMENT
2012 DEC 10 PM 3:31

The Health Care Agency has received the Internal Control Audit of the Health Care Agency Medical Billing Process for the period of March 1, 2010 through June 30, 2011. As requested, below summarizes the four (4) control findings, recommendations, and responses from the Health Care Agency Management.

Finding No. 1: Need to complete Business Continuity Planning Documents

Recommendation No. 1:
HCA continue to participate with the Countywide Business Continuity planning project and make it a priority to complete and submit the Business Continuity Fundamental Plan Components documents (Phase One).

Health Care Agency Management Response:
Concur. HCA is aware of the importance of the Business Continuity Fundamental Plan and has already made this a high priority. Since the completion of the audit review, HCA IT has made significant progress and has submitted additional documentation to CEO IT increasing the completion percentage from about 9% to over 72%.

Finding No. 2: Pre-billing and post-payment reviews for Behavioral Health Services Claims

Recommendation No. 2:
HCA evaluate its pre-billing review process for Medi-Medi Claims and determine the need to continue the current process which requires both reviews at MBU and QIPC. In addition, HCA should evaluate its pre-billing and post payment review process for Behavioral Health Services Medicare claims with consideration of frequency and sample sizes of the reviews given they are below the industry standard in the number of errors identified.



ATTACHMENT B: Health Care Agency Management Responses (continued)

Response to Internal Audit #1018, Medical Billing Process
December 7, 2012
Page 2

Health Care Agency Management Response:

Concur. During the course of this audit, the role of QIPC and MBU in the review process was analyzed and changes have already been implemented. The pre-billing review process for all Medi-Medi Claims has been modified to include only the MBU Coder review. QIPC now completes post-payment reviews on a sample basis. HCA will continue to review 100% of Medicare claims due to the conservative approach of the agency.

The post-billing review process has also been analyzed and will be adjusted to reflect the low error rate. However, as significant or critical changes occur in the billing process, such as will happen in January 2013, 100% of Medicare services will be reviewed post-payment. When it is found that the error rate is consistently at 2% or less, the post-payment review process will be modified to a sample size of about 20%. However, if the error rate at any time increases above 2%, the sample size for that program will be adjusted accordingly. In addition, if the error rate remains at or below 2% for six months, the sample size will again be decreased to about 10%.

Finding No. 3: Post-payment reviews for Public Health services claims.

Recommendation No. 3:

HCA continue to evaluate the current post-payment review process for PHS claims to determine if revision is needed to limit the sample size at a reasonable amount to enhance effectiveness and efficiency of the post-payment reviews.

Health Care Agency Management Response:

Concur. The post-payment review process for PHS claims has been modified as of April 2011 to include a reduction in the sample size for Family Pact from 20% to 10%. This will continuously be monitored and at any time the error rate shows a steady increase above the standard rate of 2%, the sample size will be adjusted accordingly. In addition, the process to determine the samples has been moved from the staff responsible for the review to the MBU IT Systems Technician who has no post-payment responsibilities. This has ensured the staff responsible for the post-payment reviews focus on their core responsibilities allowing for all reviews to be completed on a quarterly basis.

Finding No. 4: Utilization of IRIS Management Reports

Recommendation No. 4:

HCA determine the capability of IRIS for generating other management reports to assist management in monitoring the effectiveness of processes and controls for Behavioral Health Services provided and billed.

Health Care Agency Management Response:

Concur. In January 2010, there was a significant national upgrade to the Electronic Data Interchange standard. The new standard caused a complete re-design of the state's Medi-Cal adjudication system, which was not complete and stable until mid-2012, after the fieldwork was completed for this audit.



ATTACHMENT B: Health Care Agency Management Responses (continued)

- Response to Internal Audit #1018, Medical Billing Process
December 7, 2012
Page 3

Under the former standard, the IRIS team developed reports to help monitor and evaluate the processes and controls for behavioral health services provided and billed. With the implementation of the new standard, these reports needed to be modified and/or re-designed based on newly formatted information provided by the State. The audit occurred during the transition time and certain reports were unavailable. The IRIS management reports have since been modified and are currently in production.

HCA appreciates the efforts put in by the auditors in learning and documenting the medical billing process and the collaborative approach taken by Internal Audit in the finalizing of the report. Should you have any further questions, please contact Kim Engelby, HCA Accounting manager, at 714-834-5264.

Thank you.

A handwritten signature in blue ink, appearing to read "Mark A. Refowitz".

Mark A. Refowitz, Director

MAR:ke

Attachment

- cc: Bob Franz, Interim County Executive Officer
Jan Grimes, Chief-Deputy Auditor-Controller
Jeff Nagel, Deputy Agency Director, Health Care Agency
Dr. Dave Horner, Health Care Agency
Thea Bullock, Health Care Agency
Teri Schultz, Health Care Agency
Adil Siddiqui, Health Care Agency
Kim Engelby, HCA Accounting
Leslie Sorrells, HCA Accounting



ATTACHMENT C: Detailed Background of Medical Billing Process

HCA is comprised of the following four service areas:

- 1. Behavioral Health Services (BHS):** BHS provides countywide mental health care services and/or alcohol and drug abuse treatment to eligible residents. BHS consists of four divisions: **Alcohol and Drug Abuse Services (ADAS); Adult Mental Health Services (AMHS); Children and Youth Mental Health Services (CYS); and Prevention and Intervention (P&I).** HCA maintains county-operated clinics and contractor-operated clinics to provide BHS services. A majority of the BHS billings are to Medi-Cal. **During FY 10-11, HCA's billings totaled \$71,026,950 for the year.** This amount includes "self-pay" billings to clients who have a financial obligation to pay for services received. If self-pay invoices are not paid in full, the invoices are included in the subsequent month's billings. **During FY 10-11, HCA received payments totaling \$41,458,134.** These payments, including State Realignment Funds, are received in arrears, so timing differences exist.
- 2. Public Health Services (PHS):** PHS monitors the incidence of disease and injury in the community and develops preventive strategies to maintain and improve the health of the public. PHS consists of seven divisions: **California Children's Services; Disease Control and Epidemiology; Family Health; Health Promotion; Public Health Laboratory; Public Health Nursing; and Environmental Health Services.** All PHS services are provided through County-operated clinics and a majority of the billings are Medi-Cal. The MBU bills for three divisions; Disease Control and Epidemiology; Family Health; and Public Health Laboratory. **During FY 10-11, HCA's billings totaled \$1,849,114 and received payments totaling \$1,852,665.**
- 3. Medical and Institutional Health Services (MIHS):** MIHS provides emergency care and medical services to persons for whom the County, by law, has responsibility for providing such services. MIHS consists of three divisions: **Health Disaster Management; Institutional Health Services; and Medical Services Initiative Program.** The MBU bills for one division; Institutional Health Services (Orangewood Children's Home). **During FY 10-11, HCA's billings totaled \$111,816 and received payments totaling \$59,719.** Timing differences exist between amounts billed and payments received. The majority of MIHS claims are billed through Cal-Optima. We did not include MIHS in our scope due to the low volume of billings.
- 4. Financial and Administrative Services (FAS):** FAS provides internal support to HCA. Within FAS is **HCA Accounting Services**, a Satellite Accounting Unit of the Auditor-Controller. Within HCA Accounting Services is the **Medical Billing Unit (MBU).** MBU performs billings to patients and various health plans (e.g., Medi-Cal, Medicare) for medical services provided in the HCA/County-operated clinics. **Claims and Financial Reporting** within HCA Accounting Services performs cost reimbursements, reconciliations, and other accounting support services.

Medical Billing Unit

Within HCA Accounting Services is the Medical Billing Unit (MBU). The MBU provides specialized medical billing services through the Auditor-Controller's Office and supports HCA by preparing billings and claims for reimbursement for services provided to its clients in County-operated clinics. **It is important to note that MBU does not prepare or process any claims for contractor-operated clinics.** The table below shows the service areas provided through HCA/County-operated clinics and contract providers:

Detailed Results, Findings, Recommendations and Management Responses



	BHS	MIHS	PHS
County-operated Clinics	For Mental Health Services and for Court-ordered Alcohol & Drug Services	County employees provide services at Juvenile Hall and Orangewood Children's Home	For Public Health Services
Contract Entities/ Contract providers	For Mental Health Services and Alcohol & Drug Abuse Services	None	None

BHS Contract Providers

In addition to its County-operated clinics, HCA contracts with vendors (contract providers) to provide behavioral health services. These contract providers are responsible for entering their medical billings and claims (generally for Medi-Cal) directly into the County's IRIS system. The contract providers' claims are then submitted to the State for payment, in the same electronic file as the County's claims. The County receives payment for the contract provider's claims, but does not pass through payments to the contract providers. Instead, HCA pays the contract providers according to their contract agreement.

As such, HCA has only administrative responsibility over the contract provider operated clinics for ensuring services are provided; verifying proper documentation is maintained; ensuring compliance with rules and regulations; and providing training. Neither the County nor HCA have any financial obligations for any non-compliance issues by the contract providers. The contract providers are responsible for:

- Correcting and resubmitting any denied claims that are identified by HCA
- Deducting disallowed claims from future claims (system automatically withholds)
- Refunding any amounts identified during a post payment/billing audit
- Paying any recoupment and/or penalties resulting from a State claim audit
- Submitting Medicare claims directly (not part of County processes or billings)

Funding Sources for Medical Billing

HCA has various funding sources for reimbursement of medical billings. The major funding sources include Medi-Cal, Medicare, State and Federal Grants, State Mental Health Funds, State Realignment and Vehicle License Fees, and Other Health Care Plans such as Cal-Optima and Denti-Cal. Depending on the funding source, HCA prepares and submits a medical billing or a cost reimbursement claim for services provided. Various units within HCA are responsible for billing for medical services provided and/or preparing for cost reimbursement. See table below for details:

Funding Source	Billable Unit	Responsible HCA Unit	Billing/Claiming	Billing Document
Medi-Cal, Medicare	Per Service	Medical Billing Unit	Billing	837 File (electronic billing)
Other Health Care Plan (e.g. CalOptima)	Per Service	Medical Billing Unit	Billing	Paper CMS-1500 claim forms
Self-Pay (Deductibles and other out-of-pocket amount, UMDAP)	Per Service	Medical Billing Unit	Billing	Patient Statement (paper billing)
Grants (State & Federal)	Cost Reimbursement	HCA Claims and Financial Reporting	Claim Reimbursement	Claims Report
Other State Funding (Advances, Allocation, Realignment, VLF, Prop 63)	Service and Cost	HCA Claims and Financial Reporting	State funding to HCA based on pre-determined agreement/formula, e.g., Vehicle License Fee.	Cost Report to the State
County General Fund	Service and Cost	HCA Claims and Financial Reporting	Cost-applies to other County agencies	Journal Voucher



Payors have different requirements for submitting claims. For example, Medicare and Medi-Cal use specific codes to describe procedures and services performed by physicians and health care providers. Medicare requires Current Procedural Terminology (CPT) codes; whereas Medi-Cal requires Healthcare Common Procedure Coding System (HCPCS) codes for BHS and CPT codes for PHS. Also, the filing period is different between Medicare and Medi-Cal; Medicare allows for billings up to 12 months from the date of service, while Medi-Cal allows six months from the month of service to submit the billings.

Medical Billing Information Systems

HCA utilizes three key systems/software to support the medical billings:

- 1. IRIS System:** For BHS, HCA uses the Integrated Records Information System (IRIS) to facilitate billings to Medicare, Medi-Cal and other third parties, and reporting to the State of CA. IRIS functionality includes: client registration and scheduling, management and reporting of medical tests, reporting the performance and management of billing activities in compliance with State and Federal regulations, and aiding the production and exchange of health care information with external parties in a secure manner. **ProFit** is the billing module of IRIS.
- 2. Practice Expert System:** For PHS, HCA uses the Practice Expert system for registration, demographic information, reporting, and processing billings.
- 3. EDIfecs Software:** HCA utilizes EDIfecs software to perform HIPAA data validations on the electronic files prior to submitting billings and claims to the State. The State also uses EDIfecs to perform its HIPAA data validations.

Behavioral Health Services (BHS) Billing Process

BHS billings depend on the patient's eligibility and financial status. The MBU may bill either Medicare, Medi-Cal, a 3rd party health plan, the patient (known as 'Self Pay'), or a combination of billing entities for services provided. A majority of BHS billings are to Medi-Cal and about 1% is to Medicare. **Medicare claims** are required to be billed within **12 months from the date of service**. **Medi-Cal claims** are required to be billed within **six months from the month of service**. Medi-Cal allows an exception to the six-month requirement for combined Medicare/Medi-Cal claims since the claim must first be adjudicated by Medicare. **During FY 10-11, HCA billed a total of \$71,026,950**, which includes "self-pay invoices being billed repeatedly for outstanding balances, **and received payments totaling \$41,458,134**. There are 33 County-operated clinics and 86 contract providers that provide services on behalf of HCA for BHS.

The BHS billing process starts with the documentation of the clinical service and moves through the submission of electronic billing documents to the State. The billing process involves the following:

1. Financial Evaluation and Clinic Visits

Registration/Intake: Prior to providing clinic services, the patient meets with a Financial Evaluator who performs a financial evaluation to determine eligibility for various medical reimbursement programs (i.e., Medicare, Medi-Cal, Cal-Optima, etc.) and completes the evaluation in the system, which determines the client's financial responsibility. An UMDAP (Uniform Method for Determining Ability to Pay) form is produced from the system for the client to sign. The patient is registered and the financial information is entered into the applicable system (IRIS or Practice Expert).

Encounters: Each time a patient visits a clinic where services/treatments are provided, this is known as an encounter. A Progress Note and Encounter Document (ED) are completed to document services/treatments and to support the billing.

Data Entry: "Encounters" are entered into the applicable system based on the EDs. The systems perform data validations as the information is being entered.



2. Pre-Billing Reviews – BHS/Adult Mental Health

On-site pre-billing reviews are performed prior to submitting BHS billings. IRIS has various points where information is put into an electronic work queue, on a 'Hold' status, indicating a review is needed. If the claim passes the review, the 'Hold' is removed. The claim is not released for billing until all holds are cleared. Sometimes, a hold can be manually added if additional review is needed. Pre-billing reviews include **Coder Holds**, **QIPC Holds** and **MRT Holds**.

- **Coder Holds** – for BHS Medicare Claims
For services billable to Medicare, nationally certified Professional Coders (Coders) in the MBU conduct onsite coding reviews at County-operated clinics to ensure proper and accurate documentation is made on the Encounter Document and the patient chart for services provided. If it passes the MBU Coder's review, the Coder Hold is removed and the claim is ready for the QIPC (MBU) review/hold. If it does not pass the MBU Coder's review, the chart is given to the clinic for correction. Once corrected, the MBU Coder reviews the service and charts a second time, and if acceptable, releases the Coder Hold.
- **QIPC Holds** - for BHS Medicare Claims
The MBU's Medicare Unit re-verifies the patient's Medicare eligibility, confirms that the Coder has audited the service, corrects any omissions, then releases it from the work queue in IRIS for billing. If it does not pass the QIPC Holds, a corresponding hold will be manually added for additional review at the proper level.
- **MRT Holds** – for BHS Medi-Cal Claims
For services billable to Medi-Cal, the Medical Review Team (MRT) within Quality Improvement and Program Compliance Division performs onsite chart review to ensure all required information is included in the ED and Progress Notes and are in compliance prior to submitting the billing to Medi-Cal. If it does not pass the MRT Holds, the chart is returned to the clinic for correction.
- **Charge Audit/Technical Reviews** – BHS/Children & Youth Services (Medi-Cal only)
These claims are processed differently than Adult Mental Health claims. Children & Youth Services claims are not entered into IRIS until they pass Charge Audit/Technical Reviews and MRT pre-billing reviews. A Charge Audit review ensures accuracy of the billing information on the ED. Claims passing this review will go through a MRT review. Tracking sheets are maintained to monitor the status of these reviews.

Medi-Medi Benefits. If a patient is eligible for Medicare and Medi-Cal (**Medi-Medi client**), the IRIS system places the service on a Coder Hold and MRT Hold and follows the same steps as above.

When claims do not pass the pre-billing review, they may be returned to the clinic Service Chief for correction or omission. A *Services Sheet Summary* is maintained to track these 'pending' claims. There is no specific timeframe requiring clinicians to complete/correct the open claims; however, Coders and MRT follow-up with the issue on the next site visit. A claim may become 'Never Bill' if corrective actions were not taken in a timely manner.

3. Submission of Billings for Adjudication

The claims are generated in ProFit (IRIS billing module) after going through a series of system edits to validate the claim within IRIS and the EDifecs software for Medicare or Medi-Cal claims. Medicare or Medi-Cal claims are generated as electronic CMS-1500 forms. All electronic CMS-1500 forms are batched weekly into an 837 file.

- The 837 file is transmitted to the applicable claims processor. For Medicare claims, the file is uploaded through GPNET, the Palmetto Medicare GBA's Electronic Data Interchange to obtain status (acceptance/rejected/adjudicated). For Medi-Cal, the file is submitted to ITWS, the State's Information Technology Web Site. ITWS sends the file to the State's Department of Health Care Services (DHCS), where it uploads the file for adjudication.

Detailed Results, Findings, Recommendations and Management Responses



- Medi-Cal claims are processed by the State, including HIPAA edit checks using EDIfecs. If the file/claims fail any of the edit checks, the State returns the entire 837 file/claim to HCA, where it will be researched for correction and resubmission.
- Claims for Other Health Care Plans are processed on paper CMS-1500 claim forms and mailed to the insurance carrier for adjudication.

4. Adjudication of Claims - Acceptance, Denial or Rejection

About 45 to 60 days after HCA submits the 837 file, DHCS adjudicates the claims and generates an 835 file that is posted on ITWS. Once adjudicated, an 835 batch file is downloaded for posting into ProFit. There are three possible adjudications:

- **Accepted Claims.** When claims are approved by the State or Medicare, MBU receives a *Provider (Medicare) Payment Summary Report* and posts the payment into the corresponding IRIS account. HCA receives payment for all approved claims (including claims from Contractor-operated clinics) from the State. The Claims and Financial Reporting Unit in HCA Accounting posts the 837 files (for receivable and cost reporting purposes) into the subsidiary ledger and maintains a schedule to monitor the payment status. A monthly reconciliation is performed to identify and investigate discrepancies.
- **Denied Claims.** A denied status is a final adjudication for a specific claim. The denied claim will be automatically placed in the Technical Denial work queue for correction and rebilling. The denied claim can be appealed by submitting a corrected claim. MBU Medicare and Medi-Cal teams conduct research and correct the claim. Depending on how the correction is made, staff may manually cancel and re-generate the claims, and include them in the next batch submitted for adjudication. The replacement claim goes through the same system edits and manual pre-billing review cycle for re-billing of the denied service. MBU maintains a *Denial and Repay Medicare Report* and *Medi-Cal Denial Report* to keep track of all denied claims. This report is sent to QIPC and to the Compliance Coordination Committee (which includes Program Administration staff and QIPC staff) for discussion.
- **Rejected Claims.** A rejected status is not a final adjudication for a specific claim. It may be a result of failing to pass updated HIPAA rules. The State will return the entire 837 file (Medi-Cal) to HCA for correction. HCA will research the file for correction and remove the rejected claim from the 837 file. The rejected claim will be posted into a work queue for users to correct. It will follow the same workflow as the original billing.

5. Post-Billing Payment Reviews – BHS Medicare Claims

MBU Coders perform post-billing payment reviews on 100% of BHS Medicare claims to determine if there were any errors or services needing to be credited. Post payment reviews are scheduled from a monthly *Paid Claim Report*. The MBU Coder reviews the paid claims to ensure they are adequately supported, and is similar to the pre-billing audit. The results of the post-billing payment reviews are documented in a report, which is forwarded to QIPC. During our audit period, HCA repaid **70 Medicare claims totaling \$2,297** based on post-billing payment reviews, indicating that the pre-billing review process catches most of the errors or corrections needed.

Post-Billing Payment Reviews – BHS Medi-Cal Claims

HCA was under an Integrity Agreement with the Office of Inspector General for three years (December 2007 – 2010). During that time, QIPC reviewed 100% of all paid Medi-Cal claims. HCA is out of the Integrity Agreement and, therefore, is not required to review 100% of Medi-Cal claims.



Currently, the California Department of Mental Health (State) conducts an annual Medi-Cal Oversight review of the County's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. This program is administered under **Children and Youth Services (CYS)** as the program provides screening services to identify defects, conditions, and illnesses for Medi-Cal beneficiaries under 21 years old. (Note: the State does not conduct any reviews on Adult Mental Health paid claims). Any errors/non-compliance issues identified are subject to recoupment. If the error rate exceeds 5%, the State extrapolates up to 20% of all paid CYS claims during the audit period.

Public Health Services (PHS) Billing Process

PHS monitors the incidence of disease and injury in the community and develops preventive strategies to maintain and improve the health of the public. All services are provided by County-operated clinics. There are no contracted PHS clinics. MBU bills the following health programs for services provided:

- Cal-Optima
- Child Health & Disability Program (CHDP)
- Family Planning Access Care and Treatment Program (FPACT)
- Fee for Services Medi-Cal (FFS Medi-Cal): includes HIV Services and Denti-Cal (for children).

On average, HCA bills a total of \$2 million a year for PHS. MBU bills Medi-Cal and Cal-Optima on a monthly basis. There is no Medicare or self-pay for PHS, and some services are funded through grants. **During FY 10-11, HCA billed a total of \$1,849,114 and received payments totaling \$1,852,665.**

The PHS billing process involves the following steps:

- **Registration/Intake:** Similar process as with BHS billings where clinic staff verify the patient's financial status and Medi-Cal eligibility. The services are documented on a Chart and/or Encounter Document.
- **Encounters:** Clinicians complete Encounter Documents, which includes CPT billing codes. Depending on the program, there are different Encounter Documents used. Clinic staff forward the Encounter Documents to the MBU.
- **Pre-Billing Review Process:** MBU randomly selects claims (10%~100%), depending on programs, to ensure collectability prior to billing. New programs will be reviewed at 100%. MBU utilizes a checklist to conduct these pre-billing reviews on site. Any questions regarding the claims will be returned to the applicable clinic for correction. Claims not selected for a pre-billing review are entered into Practice Expert directly for billing. The billing rate is pre-established in the system so it automatically populates per the billing code. EDs that are non-compliance or requiring corrections will be returned to the corresponding clinic.
- **Submission of Billings:** Practice Expert is the billing system that generates PHS claims. This is a separate system from IRIS. PHS charges are processed in batch into Practice Expert on a daily basis. As part of claim generation, Practice Expert also verifies the claim meets program reimbursement requirements. HCA then performs the HIPAA edits using the EDifecs software. For Medi-Cal, the claims are uploaded and transmitted to the State via their website. For Cal-Optima claims, Practice Expert generates paper claims for mailing. Medi-Cal claims are processed by the State, including HIPAA edit checks. If the file/claims fail any of the edit checks, the State returns the entire 837 file/claim to HCA, where it will be researched for correction and resubmission.

Detailed Results, Findings, Recommendations and Management Responses



- State Adjudication of Claims – Acceptance, Denial or Rejection: For Medi-Cal claims, the State adjudication process is the same as for BHS Medi-Cal claims as described above. The State sends remittance forms for approved claims. Acceptance forms are entered into Practice Expert and HCA receives payments from the State.
- Post-Billing/Payment Reviews:
MBU Coders perform on site post-billing/payment reviews on only one PHS program ~ Family Pact Program (FPACT). This program is provided at one clinic only (Santa Ana 17th Street Clinic). There is no pre-billing review performed on this program as it has a high accuracy rate.