OBM | Office of Internal Audit

Department of Developmental Disabilities Direct Bill for Medicaid Audit

Audit Period: July through September 2017

Results Summary:

Objective	Conclusion*
Developmental Centers (DC) Compilation of Data for the Medicaid Direct Bill Process	**Improvement Needed**
Agency's DC Medicaid Claim Reimbursement Process	**Improvement Needed**

* Refer to Appendix A for classification of audit objective conclusions.

Report number: 2018-DDD-01 **Issuance date: July 11, 2018**

Executive Summary

Background

The Ohio Department of Developmental Disabilities' (DDD) is the primary state service agency for Ohioans with developmental disabilities. DDD pays for services provided to about 37,800 disabled individuals through three home and community-based Medicaid waiver programs, in addition to paying approximately 430 private intermediate care facilities to provide residential Medicaid services to about 5,565 residents with developmental disabilities. DDD also provides services to about 700 severely disabled individuals at eight regional developmental centers throughout the state.

DDD receives federal reimbursement for Medicaid services provided through the home and community-based waiver programs and the regional developmental centers. This engagement focuses on the regional developmental centers for which a large portion of the expenses are reimbursable under Medicaid, as the vast majority of developmental center residents are Medicaid-eligible. The federal government reimburses allowable expenditures based on a state's Federal Medical Assistance Percentages (FMAP) rate, which is determined annually by the federal government. For FFY 2017, Ohio's FMAP rate is about 62% (for every $1 spent on Medicaid-eligible services, the federal government reimburses the state about $0.62).

During the audit, OIA identified opportunities for DDD to strengthen internal controls and improve business operations. OIA conforms with the *International Standards for the Professional Practice of Internal Auditing.* OIA would like to thank DDD staff and management for their cooperation and time in support of this audit.

This report is solely intended for the information and use of agency management and the State Audit Committee. It is not intended for anyone other than these specified parties.

Scope and Objectives

OIA staff was engaged to perform an assurance audit related to the controls over the Direct Bill for Medicaid processes. This work was completed January through June 2018. The audit period was July through September 2017. The scope for this engagement included the Developmental Centers' (DC) processes over Medicaid direct billing and the agency's controls over the DC Medicaid reimbursement process. The activities carried out by the Ohio Department of Medicaid and the MITS (state Medicaid billing system) system were not within the scope of this review. The following summarizes the objectives of the review:

- Evaluate the design and effectiveness of controls over the developmental centers' compilation of data for the Medicaid direct bill process.
- Evaluate the design and effectiveness of controls over the agency's DC Medicaid claim reimbursement process.

In addition to evaluating the controls over the above processes, DDD requested OIA perform substantive testing over DC claim billing (Cambridge, Columbus, Gallipolis, Tiffin, and Warrensville DCs) to validate accuracy of claim amount based on supporting documentation maintained by the DCs.

Detailed Observations and Recommendations

The Observations and Recommendations include only those risks which were deemed high or moderate. Low risk observations were discussed with individual agency management and are not part of this report. However, the low risk observations were considered as part of the audit objective conclusions.

Observation 1 – Inadequate and Incomplete Supporting Documentation

Maintaining adequate and complete documentation provides evidence a program is achieving its legislative, regulatory, and organizational goals and requirements, as well as helps to ensure satisfactory and accurate program performance. Retention of underlying support also allows staff to substantiate work during external party reviews. OIA relied on statutory requirements, such as those contained in the Ohio Revised Code (ORC) or Ohio Administrative Code (OAC), DDD internal procedures, industry standards, and best practices to establish general expectations for supporting Developmental Centers' (DC) Medicaid claims.

In order to evaluate the current DC operating procedures over recording data and compiling documentation used to complete the Medicaid claim submissions, OIA collected information from the DCs via interviews and surveys to analyze against requirements. OIA expected some variations in each process due to the decentralized nature of key procedures being performed at each DC; overall, OIA found the current procedures utilized by the DCs to prepare and compile the Medicaid claim submissions did not appear formally developed or consistently documented. Specifically, OIA's analysis identified improvements necessary to key processes, including collection and documentation of key admission information, including verification of medical necessity, completed prior to admission; documentation and retention of key demographic information required for billing; tracking and recording daily and monthly census information and data; and logging and tracking of claim information, including submission status and paid data, within the standard billing worksheet.

OIA selected 39 claims across the five DCs to determine if the claim, prior to billing, was properly supported. The 39 claims selected were broken down by: 14 admissions, 12 discharges, and 13 friends and family leave days. While the process inadequacies noted above likely played a role in the errors noted, the testing results summarized within the table below illustrate instances in which the claims tested were not substantiated based on the documentation (or lack of documentation in some cases) provided by the DCs.

Review Attribute	Errors	Additional Notes
Formal pre-admission form/packet utilized and completed to document medical and financial/demographic information to adequately and timely determine services needed for the individual.	57% 8 of 14 admissions	For all eight admission claim errors noted, OIA could not substantiate the claim due to missing or incomplete documentation in the pre-admission packet.
Adequate documentation to support verification of consent to review Level of Care (LOC) from individual or guardian.	50% 7 of 14 admissions	Four of these errors resulted from not being able to substantiate the claim due to missing or incomplete documentation.
Adequate documentation to support verification of Medical Necessity and/or request a change in condition.	43% 6 of 14 admissions	For all six errors, OIA could not substantiate the claim due to missing or incomplete documentation.
Formal fiscal information sheet/form completed, documenting pertinent individual demographic information necessary for accurate and proper billing.	57% 8 of 14 admissions	Seven of these errors resulted from not being able to substantiate the claim due to missing or incomplete documentation.
Census Tracking - Daily Census record matches relevant documentation to support the admission date/discharge date/leave times/dates. (This document applicable across all claim types.)	23% 9 of 39 claims	Three of these errors resulted from not being able to substantiate the claim due to missing or incomplete documentation.
Adequate documentation maintained to support discharge.	100% 12 or 12 discharges	OIA could not substantiate any of the 12 claims due to missing or incomplete documentation.

Without a defined and uniform methodology to completely document and support Medicaid billing, the likelihood of variations within the billing process may increase and potentially lead to untimely, improper, or inaccurate claim submissions (initial or re-submission) and consequently, inappropriate claim reimbursement.

Recommendation

The overall methodology to establish and document support for the services provided by the DCs should be standardized. Consider organizing an agency-wide DC focus group over the DC Medicaid billing processes and procedures to collaboratively develop and document the current key procedures utilized. This will increase consistency and operational efficiencies across the DCs and allow Central Office or other DCs to easily provide assistance when necessary. The focus group could combine current ad hoc procedures and forms into one standardized process, ensuring consistency across the agency, compliance with regulatory

requirements, and assurance the services are billed accurately and appropriately by each billing representative.

Consider including the following best practices across the agency to establish adequate and complete documentation:

- Establish a formal admission packet with appropriate admission criteria, used by the program team, to record pertinent medical and financial/demographic information, including evidence of receipt of consent/authorization to review Level of Care and evaluation of medical necessity and/or change in condition.
- Establish a formal fiscal information document used by the billing representative for new admissions to the DC. The billing representative shall use this document to record pertinent information on the resident's admission, including individual demographic information necessary for accurate and proper billing obtained during the admission process, such as name, admission date, birth date, social security number, Medicaid number, waiver type, county, type of admission, etc. In addition, determine what supporting documentation should be referred to and retained to complete the fiscal form. Consider requiring the DC billing representative to sign off on the checklist acknowledging the admission information needed has been verified in order to establish the resident's billing account. The checklist allows the support for any inconsistencies to be explained, such as when the admission date and LOC date are not in agreement.
- Establish a formal census information sheet to record and compile both daily and monthly census data.
    - The daily census tracking should include cottage name, census count, admissions/discharge date and time, and detailed time of arrival and departure for any leave, specifically noting the individual's name and actual hours spent at/not at the DC.
    - The monthly compilation should include documentation to record accurate monthly totals (billable days), specifically making notes for any leave that would impact the revenue codes and the billable days for short-term individuals.

Once formal documents are established, develop policies and procedures to ensure tasks are performed consistently and completely amongst all DCs and the formalized documents are utilized as intended to support the Medicaid claims submitted. The procedures should also outline the responsibilities and duties of everyone involved in completing the formal documents and/or key procedures, expected timeframes for completion, and the retention requirements for the documents and any information obtained or created during the process. The procedures should be communicated and accessible to all employees involved in the process in a read-only format on a shared drive. Formal documents and the policies and procedures should be reviewed by management on a periodic basis and updated when necessary to accurately reflect current practices.

Management Response		
DDD will create a working group comprised of Central office and DC staff in order to determine the key criteria necessary to timely and accurately complete a client admission and the subsequent billing. This group will also review the various procedures and forms used by each DC in order to put together one process that is comprehensive of each step of the process and can be used consistently by all. *DDD Central office will include the findings for the committee to issue a comprehensive standardized policy/procedure and desk manuals. DDD Central office will provide the necessary training on the updated billing policies and procedures.*		
Risk	**Remediation Owner**	**Estimated Completion Date**
Moderate	Medicaid Health System Administrator	January 31, 2019

Observation 2 – Lack of Validation and Monitoring

Oversight and monitoring of operations and processes ensures that guidelines and requirements are being followed and procedures are being completed appropriately and timely. Additionally, monitoring reviews serve as a method of detecting and preventing future errors or deficiencies, as well as provides assurance that a desired level of quality within the processes is met. The criteria, actions, timing, and defined roles necessary to carry out such monitoring reviews should be detailed in formal procedures to help ensure successful completion of the essential processes.

Beginning in Fiscal Year 2016, the State's Developmental Centers (DC) began to electronically submit Medicaid claims monthly to receive reimbursement for services rendered as an intermediate care facility (ICF). Training was provided to the DCs prior to the implementation date of the new direct billing process; the Ohio Department of Medicaid also issued each DC a training manual which covered the basics of electronic billing utilizing the Medicaid Information Technology System (MITS). Further, a standardized Medicaid Billing Worksheet Template (Worksheet) was created by DDD Central Management based on collective input by the DCs, and is used to record specific and pertinent information from the individual monthly claims submissions and the weekly MITS remittance advice reports (payment information). The Worksheet serves as the record of claim and payment data for DDD, and provides readily available information by individual, in the instance a claim needs reviewed or resubmitted.

While the Worksheet outlines the basic information required for claim submission and related payments, each DC has developed their own procedures for compiling client billing support prior to submission, and tracking denied and resubmitted claims to resolve any variances. Although billing resources and support is continuously provided to the DCs, DDD

Central Management has not incorporated formal procedures over the billing and payment processes to be used consistently amongst all DCs, ensuring the processes are consistent and align with requirements.

OIA surveyed each DC to obtain an understanding of their billing processes and reviewed examples of tools/practices utilized by each DC, looking for best practices and key components used across the DCs. Analysis confirmed that the Worksheet is utilized by the DCs and appears to be a useful tool for recording billing data. Additionally, four of the eight DCs reported using a checklist to review admissions packets for billing information. However, during testing, the checklists requested were either not provided or the key billing information was not fully documented. Furthermore, none of the DCs had a formal procedure to ensure the compiled billing data is accurate and complete prior to MITS submittal.

The Worksheet in itself does not provide evidence that: the information recorded is accurate; the required billing information to support the claims was obtained; or the required billing procedures are completed.

In order to verify the DC Worksheets, OIA reviewed billing and corresponding payment data to ensure the information recorded in the Worksheets matched the underlying supporting claim documentation and the MITS remittance advice (RA) since the Worksheets serve as the record of claim and payment data for DDD. OIA selected 39 Medicaid claims submitted between July and September 2017 from five DCs based on claim type, including 14 admissions, 12 discharges, and 13 friends and family leave days. The first table below reflects the errors noted in which the claim data on the Worksheets did not agree with the underlying supporting documentation provided (or not provided in some cases). The second table below reflects the errors noted in which the Worksheet data did not match the RA payment information.

Table 1

Type of Information OIA Reviewed to Verify	Errors	Additional Notes
Claims containing an Admission	29% 4 of 14	One of these errors was a result of OIA not being able to substantiate the Worksheet claim due to missing or incomplete documentation.
Claims containing a Discharge	42% 5 of 12	
Claims containing Leave	62% 8 of 13	Four of these errors were a result of OIA not being able to substantiate the Worksheet claim due to missing or incomplete documentation.

Table 2

Reimbursement/Payment Data – Paid Amount	13% 7 of 39	Five of these errors were a result of OIA not being able to substantiate the Worksheet claim due to missing or incomplete documentation.

Reimbursement/Payment Data – Paid Days	18% 8 of 39	Seven of these errors were a result of OIA not being able to substantiate the Worksheet claim due to missing or incomplete documentation.

Finally, OIA noted that while DDD Central Management typically performs quarterly reviews at each of the DCs, the last review performed was in January 2017. Additionally, these reviews may cover reviews of Medicaid claims support, but it is not tested every time.

Without standardized processes to compile, submit, track, and update claim and payment information, and without periodic reviews throughout such processes, there is an increased risk of claims being submitted improperly or receiving incomplete reimbursement for services provided. Additionally, in the instance an audit would take place, DDD may not be able to properly support valid claims.

Recommendation

DDD Central Management and DC staff should collaborate to standardize the Medicaid billing processes and create a comprehensive policy and procedure manual detailing all aspects of the billing for Medicaid claims. This manual should include all required activities, timing by which each process should be completed, and the parties involved and their specific responsibilities.

Consider the following areas:

Prior to Billing

- Evidence that all pre-admission information required for billing was received by the billing representative during the admission process. Key information OIA identified from DC surveys include: admission type, financial information, signed acknowledgement, Level of Care system (LOC) date and system update date, NICS admission completion date, clinical verification (for clients without a current LOC), demographic information, date of actual admission, LOC admission date, county board bed or state funded bed, whether applying to be representative payee, type of income and amount, diagnosis identifier, insurance type (and validation that benefits are active via MITS), consent to represent for Medicaid eligibility, birth certificate, social security card, assets/bank accounts, and LOC expiration date.
- The Level of Care (LOC) system requires information be updated when there is a change in service to allow for accurate billing. Therefore, the DCs should have specific steps for ensuring this is completed timely, by the appropriate individuals, and support is retained as necessary.

Compilation of Billing Support and Completing the Worksheet

- List all documents/support required for an accurate billing. Procedures should be implemented to ensure the correct revenue code is utilized, correct patient liability amount is documented, in/out times are entered, and specific instructions should

outline what source data is to be utilized to support the information. For example, based on survey results, clarification may be needed on whether the cottage tracker is the required documentation to track any leave days, and which source document contains the accurate patient liability amount.

  - Consider creating a checklist for the billing representative to use to compile the billing claim. Include a signature line for the DC billing representative to sign after completing the checklist, acknowledging receipt of all documents needed to compile the billing claims.

- Ensure leave day/bed hold day processes and documentation support the type of leave, when it occurred, and the exact times the client was off-site.
- Improvements to the Billing Worksheet:
  - Include the LOC date and a formula to calculate the short-term room and board days based on the LOC date. This will help minimize denied claims by quickly identifying when the 90 short-term days are reached.
  - Lock cells containing formulas, both within claim lines and the variance area, to prevent intentional or inadvertent manipulation.

Resolution of Denied Claims

- Once the billing upload is complete, document specific errors/billing issues that need to be resolved because of a denied claim. Currently, the process to resubmit or adjust the denied claim is at the discretion of the billing representative, therefore, create instructions on how to resolve a denied claim. This should include when and what to track and who to contact so resolution can be timely.
- Establish a formal document to record and track claim submission and re-submission statuses, specifically noting errors and/or denied claims and the resolution. This documentation should support the history of multiple denied claims and re-submissions when they occur for one claim, including relevant claim and remittance advice (RA) numbers, in order to evidence actions taken and full resolution.
- Conduct periodic monitoring of denied claims to ensure errors and/or denials are resolved and do not exceed 180 days. The current Worksheet can be used to carry out the monitoring of denied claims, but must be used consistently and must fully document the various statuses and information related to denied claims until resolution.

Completeness of Payment

- Continue to ensure completeness of payment is monitored by updating the Worksheet with the remittance advice (payment) information and tracking monthly calculated variances on the summary billing tab(s) until resolution.
- Create a process that can be used consistently by all DCs to perform a variance review, listing common causes for variances and how to resolve. This could help new

staff or those unfamiliar with the process as variances can happen frequently. Develop a standard for DC staff to document the resolution of the variance so that all variances can be easily explained.

DDD Central Management Monitoring

- Finally, DDD Central Management should continue to perform quarterly reviews at the DCs. These should be completed and documented timely throughout the year. As a standard procedure within these reviews, DDD Central Management should review each DC's billing worksheets and test a sample of claims to verify the billing and payments are appropriately supported.

Management Response
DDD Central office will incorporate, on a sample basis, in-depth reviews of claim submissions, including looking at the supporting documentation maintained to justify the claim and ensuring payment is appropriately and completely received. This review will also serve to ensure DCs are accurately utilizing and updating the Billing Worksheet. DODD Central office will work to ensure that the sample based quarterly reviews of the DCs are performed timely.

Risk*	Remediation Owner	Estimated Completion Date
Moderate	Medicaid Health System Administrator	January 31, 2019

* Refer to Appendix A for classification of audit observations.

Due to the limited nature of our audit, we have not fully assessed the cost-benefit relationship of implementing the observations and recommendations suggested above. However, these observations reflect our continuing desire to assist your department in achieving improvements in internal controls, compliance, and operational efficiencies.

Appendix A – Classification of Conclusions and Observations

Classification of Audit Objective Conclusions

Conclusion	Description of Factors
Well-Controlled	The processes are appropriately designed and/or are operating effectively to manage risks. Control issues may exist, but are minor.
Well-Controlled with Improvement Needed	The processes have design or operating effectiveness deficiencies but do not compromise achievement of important control objectives.
Improvement Needed	Weaknesses are present that compromise achievement of one or more control objectives but do not prevent the process from achieving its overall purpose. While important weaknesses exist, their impact is not widespread.
Major Improvement Needed	Weaknesses are present that could potentially compromise achievement of its overall purpose. The impact of weaknesses on management of risks is widespread due to the number or nature of the weaknesses.

Classification of Audit Observations

Rating	Description of Factors	Reporting Level
Low	Observation poses relatively minor exposure to an agency under review. Represents a process improvement opportunity.	Agency Management; State Audit Committee (Not reported)
Moderate	Observation has moderate impact to the agency. Exposure may be significant to unit within an agency, but not to the agency as a whole. Compensating controls may exist but are not operating as designed. Requires near-term agency attention.	Agency Management and State Audit Committee
High	Observation has broad (state or agency wide) impact and possible or existing material exposure requiring immediate agency attention and remediation.	Agency Management and State Audit Committee