

# **RIPLEY CLINIC OPERATIONS**

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**Ripley Clinic Operations**

**Audit Report No. RIPC0109**

**August 14, 2009**



**MENTAL HEALTH MENTAL RETARDATION  
AUTHORITY OF HARRIS COUNTY**

**Internal Audit Report**

**AUDITOR'S REPORT**

**Ripley Clinic Operations**

**Harris County, Texas**

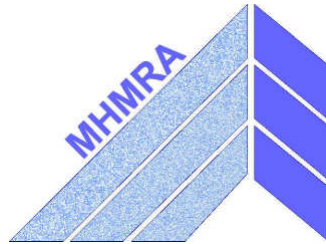
**Internal Audit Report**

**August 14, 2009**

**Henry E. Webb, CFE**

**Internal Auditor**





**MENTAL HEALTH MENTAL RETARDATION  
AUTHORITY OF HARRIS COUNTY**

August 14, 2009

Steven B. Schnee, Ph.D.  
Executive Director  
MHMRA of Harris County  
7011 SW Freeway  
Houston, TX 77074

Re: Ripley Clinic Operations  
(Report No. RIPC0109)

**BACKGROUND**

Ripley Clinic is one of the four clinics under the direction of the Deputy Director for Mental Health Services. There were approximately 1,000 open cases during the audit period. Generally, consumers served at the clinic (who are diagnosed with schizophrenia, bipolar, major depression or emotional disturbance), are adults 17 years of age or older and new consumers (intakes) referred from crisis centers, inpatient facilities, and/or other sources.

The Business Office of Ripley Clinic is currently comprised of eight employees who include the Business Office Supervisor; it supports the clinic in managing operating and financial information. The Business Office's primary function includes (re)scheduling appointments, authorizing Continuity of Care (COC), collecting payments, assessing financial eligibility, verifying consumer information, and checking consumers in and out of the clinic.

In performing these activities, various modules of the Anasazi system are utilized. The Scheduler module is used to process appointments and generate the Consumer Encounter Form (CEF) and Appointment Form. These forms are used to check consumers in and out of the clinic. Demographic and Outpatient Treatment Reviews (OTR) are conducted in the Assessment and Treatment Plan (ATP) module. These electronic forms contain consumer profiles and medical information. The Client Data module contains authorized COC plans, insurance coverage, financial review, and collection and billing information. In addition, insurance coverage is verified via WebCARE and telephone, to ensure all third-party insurance is active for service billing.

## STATE REGULATIONS

### ***TEXAS RECOMMENDED ASSESSMENT GUIDELINE FOR ADULTS, CHILDREN, AND ADOLESCENTS***

The Texas Recommended Assessment Guideline (TRAG) is a systematic assessment process for measuring mental health service needs based on consumers' recent principal diagnosis and nine dimensions for adults (AMH), and recent principal diagnosis and ten domains for children and adolescents (CAS).

As a requirement, the results of the clinical assessment must be updated in the Client Assignment and Registration (CARE) system every 90 days. To ensure the deadline is met, the Business Office communicates verified TRAG dates to providers regarding whether to reassess consumers by noting this on the CEFs. In order to bill rendered services accurately, the clinical assessments must correspond to the service package(s) authorized in the system.

### ***TEXAS ADMINISTRATIVE CODE CHAPTER 412.C – “CHARGES FOR COMMUNITY SERVICES”***

The Texas Administrative Code (TAC) Chapter 412.C was established to comply with Texas Health and Safety Code 534.067 and with the purpose to ensure that fee collection is equitable, collections are provided, and contributions to local revenue are maximized.

The following is a general highlight of the requirements:

- Financial assessment for consumers (or parents) must be conducted within the first 30 days of services and annually thereafter, except by other situations as defined in the rule. There are three criteria used to calculate Monthly Ability-to-Pay (MAP) which determines the financial obligation for consumers: income, extraordinary expense, and number of family members.
- Deferred payments are allowed for consumers with qualified financial hardships.
- Denying services to consumers is prohibited because a consumer is unable to pay for the services or because any of the following occur: incomplete financial assessment, undetermined financial responsibility, past-due account balance, involuntarily reduced or terminated services due to non-payment, or resolution of an issue relating to payment for services pending.
- Consumers have the opportunity to appeal for involuntary changes in services or referral of an approved provider because of no insurance coverage.
- The Agency is responsible for identifying all available funding sources before accessing TDMHMR funds, assisting consumers to identify approved providers, and providing assistance in applying for Federal/State benefits.
- Adults are required to apply for Supplemental Security Income (SSI) if they are eligible for Medicaid.
- The Consumer will incur standard charges for services for non-compliance of financial assessment, assignment of benefits authorization, and/or Medicaid. However, the consumer's account is allowed a retroactive adjustment if he or she complies within 30 days of the initial non-compliance.
- A plan is to be developed and implemented if there is a documented clinical determination (with consumer's team input) to address reducing compliance, discontinuing service charges, and reducing or terminating services for non-payment. The clinical determination process involves the consideration of consumer's illness, functioning level, continuation of the needed services, risk of serious deterioration of his or her health, and/or court-ordered outpatient service.

- The Agency's staff performing these tasks related to the Charges for Community Services must demonstrate initial and annual competency (MHMRA of Harris County requires a 85% passing score to satisfy the competency).

## **OBJECTIVE**

The objectives of the audit were to determine whether:

- (1) The Clinic's systems of internal controls were reasonably adequate;
- (2) The Clinic's personnel appropriately complied with applicable laws, regulations, and policies and procedures;
- (3) Financial and operating data is reasonably complete, accurate, and recorded properly in the system;
- (4) Operational resources are effectively, efficiently utilized and allocated to maximize output.

## **SCOPE**

The scope of the audit did not constitute an evaluation of the overall internal control structure of the unit. The examination was designed to evaluate and test compliance with established policies, procedures, laws, and regulations. The audit scope was for the period September 1, 2008 through May 31, 2009.

Department management is responsible for establishing and maintaining a system of internal controls to adequately comply with approved policy and procedures. The objectives of an internal control system are to provide management with reasonable, but not absolute, assurance that assets are safeguarded against loss, and that transactions are executed in accordance with management's authorization and are recorded properly.

Because of inherent limitations in any system of internal control, errors or irregularities may occur and not be detected timely. 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 procedures may deteriorate.

The purpose of the audit report is to furnish management independent, objective analyses, recommendations, and information concerning the activities reviewed. The audit report is a tool to help management discern and implement specific improvements. The audit report is not an appraisal or rating of management.

Although due professional care in the performance was exercised, this should not be construed to mean that unreported noncompliance or irregularities do not exist. The deterrence of fraud is the responsibility of management. Audit procedures alone, even when carried out with professional care, do not guarantee that fraud will be detected. Specific areas for improvement are addressed later in this report.

Other minor findings, not included in this report, have been communicated to management and/or corrected during the audit process. Internal Audit would like to thank management and staff for their cooperation throughout the audit.

## **METHODOLOGY**

In order to meet the objectives, Internal Audit flowcharted and evaluated controls over the Clinic's activities, reviewed the system relating to accounts, and reviewed laws, regulations, and policies and procedures for compliance. Information and records were obtained from the Business and Clinical Office, Eligibility Center, Information Technology, Revenue Management, and DSHS personnel. Audit tests and procedures are conducted as considered necessary.

The sample size and selection were statistically generated using a desired confidence level of 95%, an expected error rate of 5% to 6%, and a desired precision of +/-5%. Statistical sampling was used in order to infer the conclusions of test work performed on a sample of the population from which it was drawn and to obtain estimates of sampling error involved. When appropriate, judgmental sampling was used to improve the overall efficiency of the audit.

#### **STATEMENT OF AUDITING STANDARDS**

The audit was conducted in accordance with generally accepted government auditing standards (GAGAS). Those standards require that Internal Audit plan and perform the audit to afford a reasonable basis for the judgments and conclusions regarding the organization, program, activity, or function under audit. An audit also includes assessments of applicable internal controls and compliance with requirements of laws and regulations when necessary to satisfy the audit objectives. An audit also includes assessing the estimates, judgments, and decisions made by Agency management. It is believed that this audit provides a reasonable basis for the findings, conclusions, and recommendations.

#### **RESULTS**

As a result of the audit procedures and surveys conducted, it was determined that departmental compliance with established criteria to govern the Clinical activities generally meets Agency policy and procedures. However, there were areas that were noted that needed improvement over internal controls. Those areas are discussed below.

#### **FINDING**

**Section I: A. 1, 3** of the Agency Policy and Procedure for Interpretation Services states:

*“All units are to provide and maintain a current list of staff who speak languages other than English, including Sign Language, and who receive an MHMRA stipend as a certified bilingual staff.”*

*“All monolingual consumers/patients are to be assigned to certified staff unless otherwise approved by their supervisor. These certified staff are responsible for coordinating and providing services to their non-English speaking consumers.”*

It was observed that 75% of the time, the staff used for interpretative services by the Dr.'s were not certified and the supervisor had not approved the use of a non certified interpreter, the Dr. made the decision to use a particular staff member as needed. Further, one staff member used for interpretative services had not passed the certification exam after 4 attempts.

#### **RECOMMENDATION**

- It is recommended that when a non certified staff member is used for consumer interpretative services and the supervisors give prior written approval.
- It is recommended that that the non certified staff member receives the equal stipend as provided to the certified staff when providing the same/equal services.
- It is further recommended that certified staff be used to reduce the risk/exposure for the Agency and consumer when Dr.'s are conducting consumer sessions.

#### **Management Response**

*“Clinic will adhere to interpreting policy.”*

**FINDING**

After a review of 7 samples selected from consumer charts, it was determined that the Annual Demographics Consent to Disclose Consumer Health and Rights Forms were not being maintained as per Agency Policy and Procedure for the following Sections:

**Section 1: A (Rec: 014)** Assurance of Consumer Rights

**Section III: B** Content of Patient of / Consumer Records

**Section VI: A (Rec: 3)** Consent

**RECOMMENDATION**

It is recommended that all required annual forms be completed as required to ensure consumer files are current.

**Management Response**

*"Annual forms to be updated according to policy during annual financials or by staff."*

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 Henry E. Webb, CFE, Internal Auditor

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 Michele L. Johnson, MPA, Staff Internal Auditor

Cc: Rose Childs, MSW, Deputy Director, Mental Health Division  
 Kenneth Collins, LMSW, Deputy Director, Mental Retardation Division  
 Barbara Dawson, MSE, Deputy Director, Comprehensive Psychiatric Emergency Program Division  
 Daryl Knox, MD, Medical Director, Comprehensive Psychiatric Emergency Program Division  
 Sarah Flick, MD, Medical Director, Mental Retardation Services  
 Sylvia Muzquiz, MD, Medical Director, Mental Health Services  
 Jeanne Mayo, MS, JD, General Counsel  
 Alex Lim, MBA, Chief Financial Officer  
 External Audit Firm  
 Audit Committee:  
     Tom Hamilton, Ph.D. (Chairman)  
     Jane B. Cherry  
     Paige M. Cokinos  
     Charles O. Buckner, CPA  
     Vicki S. Raynold, CPA  
     Bob Borochoff

**ATTACHMENT A**  
**SUMMARY OF RECOMMENDATIONS**  
**August 14, 2009**

Unit: Ripley Clinic Area: Clinic/Business Office		
Inherent Risk: Low <b>Moderate</b> High	Control Environment: Well Controlled <b>Acceptable</b> Poorly Controlled	Overall Risk: Low <b>Moderate</b> High
Type of Procedures: <b>Audit</b>		
Scope: <ul style="list-style-type: none"> <li>* Using Internal Control Evaluation (ICEs) forms, documented the internal controls</li> <li>* Conducted a preliminary survey reviewing applicable policies and procedures, etc.</li> <li>* Interviewed various staff to obtain understanding of management controls</li> <li>* Examined detailed invoices/work orders, statements provided by the vendor, etc.</li> </ul>		
Priority Rating:  1  1	Audit Recommendations:  Adhere to Agency Policy & Procedures when using staff for interpretation services All required annual forms should be completed as required to provide current file documentation	
Follow-up: One year		

**Priority Rating**

1. Implement immediately (30 - 90 days) - Serious internal control deficiencies; or recommendations to reduce cost, maximize revenues, or improve internal controls that can be easily implemented.
2. Work towards implementing (6 - 18 months) - Less serious internal control deficiencies, or recommendations that can not be implemented immediately because of constraints imposed on the unit (i.e. Budgetary, technological constraints, etc.).
3. Implement in the future (2-3 years) - Recommendations that should be implemented, but that can not be implemented until significant and/or uncontrolled events occur (i.e. legislative changes, buy and install major systems, or require third party cooperation, etc.).