

NORTHWEST CLINIC / BUSINESS OFFICE

Audit Report No. NWBCO110

February 12, 2010



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

Internal Audit Report

AUDITOR'S REPORT

Northwest Business Office / Clinic

Harris County, Texas

Internal Audit Report

February 12, 2010

Henry E. Webb, CFE

Internal Auditor





February 12, 2010

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

Re: Northwest Business Office/Clinic
(Report No. NWBC0110)

BACKGROUND

Northwest Clinic and Business Office is one of the four locations under the direction of the Assistant Deputy Director for Mental Health Services. There were approximately 6,784 open cases during the audit period. Consumers, served at the clinic, who are diagnosed with schizophrenia, bipolar, major depression or emotional disturbance, are adults 18 years of age or older, children and adolescents from 3 to 17 years of age, and new consumers (intakes) referred from crisis centers, inpatient facilities, and/or other sources. The Northwest Clinic is also the location for the Assertive Community Treatment (ACT) Team.

The Business Office of Northwest Clinic is comprised of 11 employees and supports the clinic in managing operating and financial information. The Business Office's primary function includes scheduling appointments, authorizing Continuity of Care (COC), collecting payments, assessing financial eligibility, 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. Financials are also generated in the Quad System allowing Harris County and other State Agencies access to consumer information.

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 the consumer’s recent principal diagnosis and nine dimensions for adults (AMH), and recent principal diagnosis and 10 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 that the deadline is met, the Business Office communicates verified TRAG dates to providers regarding whether to reassess consumers by noting the data on the CEFs. In order to bill rendered services accurately, they must correspond to the service package(s) authorized in the system.

As the level of service packages moves from lower to higher numbers, the treatment becomes more intensive and costly. Some services are overlapped among the packages, while others are not.

Table 1 presents the overview of service packages available at Northwest Clinic for AMH and CAS:

**Table 1
Service Packages
NW Clinic AMH/CAS**

Service Packages for:	INTENSIVE Sp1	AMH			CAS						
		1	2	3	1.1	1.2	2.2	2.3	2.4	4	
Service Description:											
Pharmacological Management											
Medication Training and Supports											
Routine Case Management											
Skills Training and Development											
Rehabilitative Counseling and Psychotherapy											
Psychosocial Rehabilitation											
Supported Employment											
Medical Services											
Brief Outpatient – Externalizing Disorders											
Brief Outpatient – Internalizing Disorders											
Intensive Outpatient – Externalizing Disorders											
Intensive Outpatient – Internalizing Disorders											
Intensive Outpatient – Bipolar, Schizophrenia or other psychotic disorders											
Aftercare											
Patient/Family Education											

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

The Texas Administrative Code (TAC) Chapter 412.C was established to comply with the Texas Health and Safety Code 534.067 and with the purpose 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 the 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, assisting consumers to identify approved providers, and providing assistance in applying for Federal/State benefits.
- Children are required to enroll in Medicaid or Children's Health Insurance Program (CHIP) if their parents are eligible for these funds.
- Adults are required to apply for Supplemental Security Income (SSI) if they are eligible for Medicaid.
- The Consumer (or parent) will incur standard charges for services for non-compliance of financial assessment, assignment of benefits authorization, and/or Medicaid or CHIP enrollment for CAS. 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 the 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 85% passing score to satisfy the competency).

OBJECTIVE

The objectives of the audit were:

- (1) To determine whether the Business Office/Clinic system of internal controls were reasonably adequate;
- (2) To determine whether the Business Office/Clinic personnel appropriately complied with applicable laws, regulations, policies and procedures;
- (3) To determine whether financial and operating data is complete, accurate, and recorded properly in the system.

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, 2009 through December 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 Business Office activities, reviewed the system relating to accounts, and reviewed laws, regulations, 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 were conducted as considered necessary.

The sample size and selection were statistically generated using a desired confidence level of 95%, expected error rate of 6 to 7%, 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 Business Office/Clinic activities generally meet Agency policy and procedures, except for the findings presented in the body of the report.

FINDING

Use of Non Certified Interpreters

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 20% of the time, the staff used for interpretative services by the physicians was not certified and the supervisor had not approved the use of a non certified interpreter. The physicians make the decision to use a particular staff member as needed

RECOMMENDATION

- It is recommended that when a non certified staff member is used for consumer interpretative services that the supervisors give prior written approval.
- It is recommended that the non certified staff member receive 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 physicians are conducting consumer sessions.

Management Response

“The Business Office will comply with Agency policy that staff will not interpret unless certified through the Agency.”

FINDING

Lack of Adhering To Established Policy

After a review of 30 samples (15 adult and 15 children charts) selected from consumer records, it was determined that 17 records or 56% had a variation of required forms that were not in compliance. Those records included expired TRAGS, treatment plans, Annual Demographics, as well as financials that were not being maintained as per Agency Policy and Procedure for the following Sections:

Section III: B Content of Patient of / Consumer Records

RECOMMENDATION

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

Management Response

“We will update all identified forms immediately.”

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Henry E. Webb, CFE, Internal Auditor

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, CPA, Chief Financial Officer
Scott Strang, Ph.D., MBA, Chief Operating 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
February 12, 2010

Unit: Northwest Business Office / Clinic		
Area: Business Office / Clinic		
Inherent Risk:	Control Environment:	Overall Risk:
Low <i>Moderate</i> High	Well Controlled <i>Acceptable</i> Poorly Controlled	Low <i>Moderate</i> High
Type of Procedures: Audit		
Scope: <ul style="list-style-type: none"> * Using Internal Control Evaluation (ICEs) forms, documented the internal controls * Conducted a preliminary survey reviewing applicable policies and procedures, etc. * Interviewed various staff to obtain understanding of management controls * Examined detailed invoices/work orders, statements provided by the vendor, etc. 		
Priority Rating:	Audit Recommendations:	
1	Use certified interpreters as outlined in Agency Policy and Procedures	
1	Review and complete all required annual forms as outlined in Agency Policy and Procedures	
Follow-up: Six months		

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.).