



FULTON COUNTY, GEORGIA

OFFICE OF INTERNAL AUDIT

FULTON COUNTY HEALTH & HUMAN SERVICES

**REVIEW OF THE BILLING AND
COLLECTIONS DIVISION**

March 15, 2012

Table of Contents

	Page
Introduction	1
Background	1
Objectives	2
Scope	2
Methodology	2
Findings & Response to Findings	2 - 8

Introduction

Fulton County's Health & Wellness (Public Health) and Behavioral Health & Developmental Disabilities departments are responsible for coordinating and providing health and human services in collaboration with the justice system and community partners. The clinician unit is responsible for initiating claims and correcting related errors and ensuring that all medical claims are in compliance with contractual agreements and state and federal regulations. The billing and collection unit is responsible for electronically transmitting claims to third party payers which are created by the clinical staff in the health centers. The billing and collection unit is also responsible for claims denial management; initial and ongoing credentialing of health centers and clinical professionals; tracking claims errors; and training clinical staff to eliminate or reduce billing errors.

It is the policy of the Fulton County that every service provided has a fee structure and that every client should be evaluated for the ability to pay at the time of service delivery. Billings for medical care are sent to Care Managed Organizations (CMOs), insurance companies, and where appropriate, third party payers such as Medicaid and Medicare are billed for healthcare services provided to the clients. Individuals without insurance or other supportive coverage are charged on a sliding fee scale.

Background

The Fulton County Department of Health & Wellness was established in 1952 and is the only public health agency in the State of Georgia that is under the auspices of local government. Today services have evolved to include both preventive care and treatment in the following areas: 1) infectious diseases; 2) women and child healthcare; 3) environmental health; and 4) other public health services, including education, refugee screenings, and various preventative programs. There are eight centers which provide these services. Two centers, the North Annex Service Center and the Neighborhood Union Health Center, provide healthcare and social services on a collaborative basis with the objective of providing the residents with centralized access to health services under one roof to support overall wellness. The North Annex and Neighborhood Union centers also partner with doctors from the Morehouse School of Medicine for the delivery of health services.

The Fulton County Department of Behavioral Health & Developmental Disabilities provides behavioral health care services to the most-in-need citizens of Fulton County. Included in its client population is a very large uninsured population. The services provided are designed to help citizens achieve and maintain independence and stability so that they can play a more productive role within their families and community. Services provided are classified under three categories: Mental, Developmental, and Addictive diseases. There are nine centers that provide these services, which includes the North Annex and Neighborhood Union centers.

Combined, the Departments of Health & Wellness and Behavioral Health & Developmental Disabilities is the largest county health department in the State of Georgia, covering a 535 square mile area encompassing approximately 88 percent of the City of Atlanta. The healthcare facilities are easily accessible, and there are mobile units which provide transportation support to the healthcare facilities.

Review of Fulton County's HHS Billing and Collection Division

Objectives

The objective of our review of the billing and collection unit of Fulton County's Health & Human Services was to obtain an understanding of the Health & Wellness and the Behavioral Health & Developmental Disabilities departmental processes and procedures for originating, billing, and collecting healthcare claims. Our objective for revenue enhancement was to determine what actions should be implemented to reduce billing errors and increase the amount of claims or billings collections.

Scope

January 1, 2010 through January 31, 2011.

Methodology

Key personnel were interviewed to obtain an understanding of the screening and intake process for clients requesting healthcare services. We documented our understanding of the standard operating procedures for originating, processing, and submitting medical claims and for collecting and reporting claims denials and receipts. Medicaid and Medicare rules and contracts with intermediary payers were also reviewed.

We selected six weekly and biweekly periods for testing of the claims that Medicaid and Medicare returned unpaid (claim denials). Claim denials were randomly selected and tested for errors, corrections, resubmissions, and denial explanations. Furthermore, the rejected claims were grouped into similar classes to determine the frequency and the relative loss of revenue from denials.

Any unusual circumstances affecting the billing and collection cycle, were identified and the effects documented. The aging receivable reports were reviewed and the total claims deemed uncollectible were tested for reasonableness.

Finding #1: Health & Wellness claims deemed not collectible

Best practices for managing healthcare billings and collections require that skilled administrative personnel be assigned the tasks of obtaining the insurance carrier's pre-approval of the medical procedures. In addition, those personnel should prepare and submit the medical billings on a timely basis while using the appropriate medical billing codes, securing the confidentiality of patient information, and ensuring that the correct claim's information is submitted.

We randomly selected and reviewed claims billed from six weekly and bi-weekly billing periods. We were satisfied that the claims billed and collected were appropriately reported and supported by remittance advices. Therefore we focused our review on the causes of the denied claims. Health and Wellness has the ability to recover any claim denied by submitting additional information to substantiate the claim. Our focus was on whether or not a denied claim was recoverable. A sample of ninety-seven (97) denied claims were randomly selected and reviewed to determine if they were recoverable. Five percent (5%) of the denied claims were resubmitted for billing, resulting in two percent (2%) of the resubmitted claims being collected and three

Review of Fulton County's HHS Billing and Collection Division

percent (3%) of the resubmitted claims were pending collection. The resulting ninety-five percent (95%) of the denied claims were deemed not collectible based on the following reasons:

- Twenty-two percent (22%) were rejected because invalid claim information was filed, including procedure and modifier codes.
- Twenty percent (20%) were rejected because of late filing.
- Seventeen percent (17%) were rejected because the medical provider was not enrolled in the required electronic filing network.
- Seven percent (7%) were rejected because the primary insurer was not billed.
- Six percent (6%) were rejected because the wrong place of service or provider was indicated.
- Four percent (4%) were rejected because clients were Medicaid/Medicare ineligible.
- Four percent (4%) were rejected due to duplicate filing.
- Three percent (3%) were rejected due to insufficient information for adjudication or no authorization for services on file.
- Six percent (6%) of the claims rejected were either not covered by the listed CMO or had an invalid CLIA certification
- Six percent (6%) were rejected for various other reasons.

We concluded that the rate of rejections was directly related to the failure of utilizing the full electronic billing capability of the M&M system and the shortage of skilled staff. According to the Director, training, increasing staff, and using the existing electronic billing software will greatly reduce the claims denials and increase the collection rate. Currently, there are four people responsible for the claim denials of eight Health and Wellness Centers. These four Centers recorded 128,736 patient visits in 2010, or approximately 495 visits per day.

Recommendation

The Interim Director is currently addressing the issues of developing staff skills, setting up the electronic M&M billing platform, and providing more resources for claim denial processing. We recommend that management support these efforts to strengthen controls over claims processing and collections.

Response to Finding #1: Uncollectible Health and Wellness claim denials

Prior to June, 2010 the process used by Health and Wellness Department for billing medical claims was performed manually. Health and Wellness was found to be in phase two of completing the installation of the Mitchell & McCormick Visual Health Net System (M&M). The installation is implemented in three phases which is the set-up of the equipment, testing and training on the clinical software and the set-up, testing and training on the electronic billing software.

The merger of the Health and Wellness and Behavioral Health billing staff in January, 2010, afforded Health and Wellness with four (4) trained staff from Behavioral Health with experience in billing claims electronically and denial management. After six months of working with M&M to complete the set up and train the health center administrative staff, the initial electronic

Review of Fulton County's HHS Billing and Collection Division

transmission to the insurance companies was accomplished in June, 2010. The billing for the next few months contained all claims entered in the M&M system by the clinical staff from 2006 through 2010. It was discovered that many of the claims were never billed which attributes to the large percentage 20% and 22% of denied claims with an error rate of "late filing" codes. At this point, it was impossible to correct the errors because the deadline for resubmitting denied claims had lapsed.

There were a large number of denials and difficulty in completing all of the work primarily because the unit only has a few staff with denial management experience. The Behavioral Health billing staff is at a higher DBM, which is well within their job specifications. The two (2) Health and Wellness staff has a lower DBM (Accountant I B23) versus the Behavioral Health staff (Financial Service Coordinators C43). Therefore only certain aspects of the job could be assigned to the Accountant I employees. The sixteen percent 16% errors occurred because many providers did not have electronic data exchange (EDI) clearance, which was discovered and corrected after the initial billing. The remaining errors are "point of service" errors that occur in the health centers and training with consistent monitoring by management will reduce the rate.

Finding #2: Significant Number of Health & Wellness electronic patient billing files were not retained

In order to maintain an efficient and effective system of billing and collections for medical services rendered, the staff should be appropriately trained and the full capabilities of the electronic billing system should be utilized along with monitoring support.

During our review of the Health & Wellness Department's patients' billing records, we found that sixty-one (61) of the patient's electronic billing files were not retained in the M&M system by ACS or HP Enterprises. This is the State of Georgia's pay intermediary contractors. As a result, the rejected claims could not be analyzed, corrected and resubmitted. This condition occurred because patients' files and billing data were not properly transferred, when the contractors changed from ACS to HP Enterprises. Additionally, the M&M billing module was not being used; instead, claims were manually processed and submitted through the web portal set-up for ACS. Subsequently claims, totaling \$3.655, were denied and not resubmitted.

Recommendation

The Fulton County Department of Health & Wellness should continue to train staff to use an effective claims denial protocol and periodically conduct claims denial audits. In 2011, the training process was begun by the Director who implemented the utilization of the billing platform in the M&M system to electronically transmit billings and claims for medical services rendered. Additionally, the entire Public Health clinical and administrative staff has been trained to use the complete M&M system. An acceptable recovery rate should be developed as a metric measurement tool for evaluating performance.

Response to Finding #2: Significant Number of Health & Wellness electronic patient billing files were not retained

The state of Georgia contracted with a new a Medicaid intermediary in November, 2010. The transition from its former business partner to the present caused a major disruption in Medicaid billing throughout the state. There were multiple issues that affected the Public Health Districts and one that was a major problem for Fulton County Health and Wellness. The decision by the state to not transfer all of the existing claim files to the new intermediary system hampered the recoupment effort of the denied claims. The billing staff was still working through a huge backlog of claims which was time consuming because the M&M system did not have an account receivables report that could be used as a tool for working denials. Denials must be worked by accessing individual client accounts and if all outstanding accounts are on one report, it is less time consuming then using an insurance report. The staff had to work the denials manually. The billing unit continues to work with M&M to solve the problem.

Finding #3: Uncollectible Behavioral Health & Developmental Disabilities claim denials

One of the most important aspects of managing healthcare costs is the timely processing and collection of claims. To accomplish this, staff must confirm that pre-approvals for services are obtained; billings are submitted timely; appropriate procedure and modifier codes are reported; and the correct claim information is submitted, which must occur at the point of service. In the Department of Behavioral Health & Developmental Disabilities, we tested a sample of one hundred forty-five (145) claim denials. Health and Wellness has the ability to recover any claim denied by submitting additional information to substantiate the claim. Of the denied claims we reviewed, forty-three percent (43%) were deemed uncollectible. Further analysis of the rejected claims revealed the following:

- Fifteen percent (15%) were rejected because of Medicaid and Medicare related problems.
- Six percent (6%) were rejected because the provider was not eligible for the services billed.
- Five percent (5%) were rejected because the bill is the patient's responsibility.
- Five percent (5%) were rejected because no prior authorization was obtained for the procedure.
- Five percent (5%) were rejected because the wrong amount was billed and the time for recovery lapsed.
- Four percent (4%) were rejected because the primary insurer was not billed.
- Two percent (2%) were rejected because no service tickets were found to support claims.
- One percent (1%) was rejected either because the wrong procedure/authorization code was reported or the maximum benefit limit had been reached.

The high percentage of claim losses, due to denials or rejections, occurred because of the transition to a new pay intermediary and because of the shortage of skilled staff to process the claims. Our sample test results yielded a fifty-four percent (54%) recovery rate for denied claims.

Recommendation

The Fulton County Department of Behavioral Health and Developmental Disabilities should continue to train staff to use effective claims denial procedures to recover costs and periodically conduct claims denial audits. An acceptable recovery rate should be developed as a metric measurement tool for evaluating performance.

Response to Finding #3: Uncollectible Behavioral Health & Developmental Disabilities claim denials

The Behavioral Health M&M system version was developed in the 1990s. There have been upgrades throughout the years however the software is not as advanced as the Health and Wellness M&M instrument. The Behavioral Health system is a paper driven system at the "point of service" which has the potential of increasing error rates if not managed effectively because another layer of staff input the codes. In comparison, Public Health system is paperless and at the "point of service" the clinical staff input codes and diagnoses as they provide services. The Billing and Collections unit tracks the errors and provides Behavioral Health management with the data and training to help reduce the rate of denials. The majority of the errors were preventable however the Billing and Collections staff were stretched with the demands of Public Health training needs. There are only 2 trainers available now that one of our positions was unfunded. We are attempting to come up with a plan to stretch our resources by finding training videos/tapes that are self-instructional.

Finding #4: Incorrect classification of Behavioral Health & Developmental Disabilities uncollectable claims

Proper classification of transactions in the accounting and financial reporting system is required if accurate receivables and billing account balances are to be reported. Our test of the Department of Behavioral Health & Developmental Disabilities' uncollectible claims indicates that thirty-four percent (34%) of the claims, totaling \$504,499, were incorrectly classified under the State Contract and Grant-In-Aid Programs.

Patients continued to be classified for assistance under the State Contract and Grant-In-Aid Programs after the funding had been exhausted. The patients should have been classified as uninsured and indigent. The incorrect classifications are the result of the limitations of the M&M billing software system. By classifying these patients under the State Contract and Grant-In-Aid Programs, opportunities were lost for collecting these delinquent account balances or for qualifying the patients for reimbursement under the Medicaid program.

Recommendation

Recently, the Director of Health Services changed the policy for charging and classifying patients' accounts under the State Contract and State Grant-In-Aid Programs. The new policy should prohibit registering patients under the State Contract and Grant-In-Aid Programs when the funding limit is reached.

Response to Finding #4: Incorrect classification of Behavioral Health & Developmental Disabilities uncollectable claims

Agree with the recommendation the policy change will improve reporting.

Finding #5: Discharge of Uncollectible Claims

The best practice for effective collection of medical claims is to act on the claims based on each payer's individual processing and remittance plan. This practice recognizes the unique contractual obligations, policies and procedures, and instructions of each payer or insurer. Additionally, claim receivables should be analyzed daily or weekly and electronically to determine their collectability or discharge status.

We analyzed the schedule of aged receivables presented from July 2006 through June 15, 2011 for the Health and Wellness Division. This schedule was prepared at the request of the Interim Director and was the first such aging claims receivable report generated by the M&M management information system.

For the period from July 2006 to June 15, 2011, the total amount of claims listed on the Aged Payers Report was \$9,988,089. We determined that \$7,439,058 or 74.5% of the claims should be discharged as uncollectible. The receivables should be deemed uncollectible because they were not collected within the contractual or established collection time period. Of the uncollectible receivables \$324,527 of the amount consists of claims incurred under Federal Programs which limit reimbursements based on contractual terms and amounts. The remaining claims are patient obligations or self-pay claims. The uncollectible status of the claims receivables can be attributed to not having the software which analyzes and periodically reports aged receivables and which automates collection incidents.

Recommendation

The Accounts Receivables should be analyzed electronically daily to determine their collectability or discharge status. If this is not possible, the receivables should be stratified by payer and analyzed weekly based on each payer's payment plan or schedule. Those claims deemed collectible should be aggressively collected or assigned to a collection agency as quick as possible. An analysis of the receivables should be done for the year ending December 31, 2011. If a collection agency is engaged, the County should review and approve the agency's protocol for collecting the claims. This will ensure that the agency's collection activities adhere to the special terms and conditions included in the agreements between Fulton County and the Federal or State agencies and insurance intermediaries.

A document stating the nature of the amount to be discharged should be required for claims exceeding a predetermined threshold. This document should include:

1. Name(s) of the person(s) or payer (s) liable for the balance due.
2. Estimated cost of collection incurred.
3. Any other fact(s) supporting the request for discharge, including offset attempts.

Review of Fulton County's HHS Billing and Collection Division

4. If the discharge from accountability is due to bankruptcy, the supporting documentation must include a copy of the court's final discharge of the debtor and evidence that the specific debt is included in the petition for bankruptcy.
5. Signature, printed name, and title of manager authorizing the discharge.

Response to Finding #5: Discharge of Uncollectible Claims

Agree with the recommendation regarding the discharge and collection of the receivables.