

Final  
Advisory  
Memorandum

Montgomery County Department of Health  
and Human Services

# Healthcare Billing Practices

Report # OIG-17-002

November 30, 2016

---

Montgomery County Maryland  
Office of the Inspector General





**OFFICE OF THE INSPECTOR GENERAL**

**FINAL ADVISORY MEMORANDUM**

November 30, 2016

**TO:** Timothy L. Firestine  
Chief Administrative Officer (CAO)

**FROM:** Edward L. Blansitt III  
Inspector General

**SUBJECT:** DHHS Healthcare Billing Practices  
OIG Report #17-002

In August 2015, the Montgomery County Office of the Inspector General (OIG) received a complaint alleging ineffective billing of insurers for DHHS-provided medical services for behavioral health. The complainant reported that DHHS recently hired a consultant to find out why DHHS fails to bill effectively. However, despite the contractor's analysis, behavioral health programs continue to struggle with timely billing and the submission of clean claims that can be readily approved by insurance carriers for payment.

Our review was conducted in accordance with *Government Auditing Standards* issued by the U.S. Government Accountability Office and *Principles and Standards for Offices of Inspector General* issued by the Association of Inspectors General.

**Introduction and Background:**

The operation and funding of DHHS programs are largely independent of the fees collected. All DHHS program revenue goes to the General Fund with one small exception.<sup>1</sup> Each year the County Council approves the annual budget for the Montgomery County Department of Health and Human Services (DHHS). The approved FY2017 DHHS budget indicates that approximately 26% of DHHS expenditures will be

---

<sup>1</sup> A condition of the grant award to the Infants and Toddlers Program requires that Medicaid funds collected be used to fund the program. The Infants and Toddlers Program represents less than 2% of the FY2017 DHHS budget.

funded by grants<sup>2</sup>, while the remaining portion of the \$299 million budget will come from the General Fund.

For some of the programs provided by DHHS, there is an untapped opportunity to collect additional revenues through insurance billing, client fees, or donations. DHHS advised us that it has already had some success in this area. OIG staff learned that, in May 2014, the County engaged Health Management Consultants, LLC (HMC) to provide “medical billing revenue maximization consulting services.” (Contract No. 1035850) This appears to be the consulting contract referenced in the complaint.

DHHS explained that the decision to enter into the HMC contract was self-initiated in FY2014 due to multiple circumstances. First, the Affordable Care Act accelerated an existing trend for public and behavioral health programs to replace grant funding with fee-for-service arrangements. This created a need for DHHS to explore billing opportunities in order to generate the revenue necessary to maintain service levels. Second, the recent changeover from paper health records to the NextGen Electronic Health Record (EHR) system has given DHHS the capability to bill for more services.

**Objectives, Scope and Methodology:**

The OIG staff conducted this inquiry in order to:

- (1) understand the scope of the HMC contract with DHHS;
- (2) determine if HMC’s recommendations for improved efficiency while maximizing billing revenue were reasonable;
- (3) determine if DHHS was properly implementing HMC’s recommendations.

We analyzed the contract and associated reports and work plans, reviewed applicable laws and regulations, and interviewed DHHS management.

**Inquiry and Outcomes:**

In September 2015, OIG staff received a copy of the HMC contract and amendments, as well as all task orders issued to date. Additionally, the OIG received information regarding services and deliverables to the extent that contracted task orders have been satisfied. OIG staff reviewed these documents and found that Task Order 1 (New Opportunities Task Order) and Task Order 4 (Current Billing Task Order) were the most relevant to the complaint that we received. Our inquiry focused on the outcomes of those task orders.

***Current Billing Task Order: HMC’s Review of Charting and Coding Practices***

---

The Current Billing Task Order focused on improving revenue collection within programs that currently bill for services. This task order required an analysis of current coding and billing practices in the behavioral health and public health programs in order to develop recommendations for billing maximization and also included an assessment of

---

<sup>2</sup> DHHS stated that the Medicaid funds collected by the Infants and Toddlers Program are listed in the budget as grant funds.

the impact of the recent DHHS implementation of the NextGen EHR. NextGen EHR was implemented primarily during FY2015 and is designed to address a number of the billing challenges for the DHHS programs.

In October 2015, OIG staff reviewed the Current Billing Task Order report which HMC submitted to DHHS in May 2015. HMC analyzed claim denials, which can require significant labor hours before claim resubmission and may result in a lack of payment if time frames for claim resubmission have expired. HMC stated that the goal of clean claim submission requires coordinated effort between clinicians and billing staff and identified needed improvements in communication between the two.

HMC recommended that DHHS adopt a standardized approach to clinical records and better organization of billing documents. HMC also pointed out a need for managerial staff to set, track, and communicate productivity and performance goals and to improve analysis and oversight of clinical services and billing activities.

**Finding 1: While DHHS stated that the implementation of the NextGen Electronic Health Record (EHR) has resulted in a better ability to track a number of analytics regarding medical billing, DHHS did not present a formal plan to hold staff and management accountable for successful and timely billing as recommended in the HMC report.**

In November 2015, OIG staff met with the DHHS Chief Operating Officer and the Fiscal Team Manager to discuss the HMC task order report and any steps taken by DHHS to address the contractor's findings and recommendations. During the meeting, OIG staff learned that DHHS management did not have a formal, written plan to implement the contractor's recommendations, but indicated that it had recently taken a number of steps designed to improve the efficiency of the current billing process. Principally, DHHS advised us that it had implemented the NextGen EHR system, hired a practice manager to run the business side of the clinical practice, and added use of the new technology to employee performance plans.

In March 2016, OIG staff met with the DHHS Acting Chief Operating Officer. At that meeting DHHS demonstrated that it was now tracking a number of analytics regarding revenue maximization in the programs currently being billed, including error rates and types, claim edits, and payer denials.

In August 2016, DHHS management stated that the consistent data provided by the NextGen EHR system has allowed DHHS to pinpoint particular problems, including specific DHHS locations that are not billing properly and poor performance by particular employees. DHHS management advised us that it gave extra resources and hired new staff to address some of the problems identified through the data produced by the new system. However, DHHS management also stated that it had instructed staff at one location to completely stop billing for services for the past year due to unspecified problems. We did not further explore the nature of the problems.

Despite some difficulties with particular staff or locations, DHHS provided information indicating that during the NextGen EHR implementation, DHHS Medicaid/Medicare revenue collections increased from \$3.94 million in FY2014 to \$4.37 million in FY2015.

It is reasonable to expect that reimbursements would increase significantly in FY2016 and FY2017 following the full implementation of the NextGen EHR system.

**Recommendation 1:**

---

**DHHS should develop a formal plan to hold managers and staff accountable for accurate, timely, and effective billing and collection.**

***New Opportunities Task Order: HMC's Assessment of Billing Opportunities***

---

The New Opportunities Task Order focused on DHHS programs that do not currently bill for services. HMC identified new opportunities for increasing revenues from Medicaid and Medicare for two DHHS programs: the Crisis Center and the Access Program, which together provide a variety of assessments, referrals, and short-term treatment services to County residents with mental health and substance abuse disorder conditions each year. At the time of the analysis, neither program billed insurance for services costing over \$8 million each year.

<b>DHHS Program</b>	<b>FY17 Budget</b>
24-Hour Crisis Center	\$5,072,214
Access to Behavioral Health Services	\$3,711,501

HMC did not provide an estimate of the portion of services provided that may be billable. However, DHHS staff believes that a substantial portion of the individuals served are either Medicaid beneficiaries, Medicaid eligible, and/or Medicare eligible.

In October 2015, OIG staff reviewed the New Opportunities Task Order report which HMC submitted to DHHS in April 2015. In its report, HMC identified the following services provided by the Crisis Center or Access Program that HMC believed could be reimbursed by Medicaid and/or Medicare.

- Residential Crisis Services
- Access Program Mental Health Assessments
- Crisis Center Mental Health Assessments
- Crisis Center Evaluation and Management (E&M)
- Substance Use Disorder Assessments (SUD)
- Mobile Treatment Services

HMC recommended that DHHS begin billing for these services and outlined some changes in staff responsibilities or service levels to allow for these services to be billed.

**Finding 2: While HMC recommended that DHHS seek reimbursement for a number of medical services provided by the Crisis Center and Access Program, medical billing has been fully implemented in only one of the 5 feasible areas recommended by the contractor.**

Little information was provided related to the implementation of New Opportunities Task Order recommendations at the November 2015 meeting with the DHHS Chief Operating Officer and the Fiscal Team Manager. OIG and DHHS management agreed to meet again to discuss DHHS progress in addressing the HMC recommendations. Additionally, OIG staff requested that DHHS develop a written action plan to track its implementation of the New Opportunities Task Order recommendations.

At the subsequent meeting in March 2016, OIG staff were provided a draft work plan regarding the HMC recommendations outlined in the New Opportunities Task Order. The draft work plan indicated that DHHS implemented the contractor recommendation to begin billing in Residential Crisis Services and rejected the contractor's recommendation to begin billing for Mobile Treatment Services. DHHS asserts that it offers Mobile Crisis Services, not Mobile Treatment Services. Mobile Crisis Services are included on the Maryland Department of Health and Mental Hygiene non-chargeable list.

The work plan indicated that for the other 4 areas in which the contractor recommended that DHHS initiate billing, DHHS had identified a number of outstanding questions that would need to be resolved to implement the recommendations. Overall, the bulk of the items included on the New Opportunities Task Order work plan were to be performed in the future. The DHHS Acting Chief Operating Officer stated that DHHS planned to formalize an action plan and present it to the DHHS Director by June 30, 2016.

In August 2016, OIG staff met with the DHHS Chief Operating Officer to learn whether the New Opportunities Task Order work plan had been finalized and what concrete steps had been taken to implement the recommendations. DHHS advised us that it had taken steps to begin billing for transitional behavioral health services in the Crisis Center and Access Program. The majority of Mental Health Assessments are provided clients who are seen in a singular encounter (i.e. "walk-in services"). For those clients, DHHS identified additional questions to be answered and steps to be completed before billing was feasible. Although DHHS has not fully implemented billing in most of the feasible areas suggested by the contractor, DHHS now has a concrete plan in place to move toward opening new revenue streams.

The chart below summarizes progress on each of the recommendations as reported by DHHS. DHHS reports that, to date, only the recommendation concerning billing for Residential Treatment Services has been fully implemented.

<b>Potential Billing Opportunities</b>	<b>Recommendation Status (as Reported by DHHS)</b>
Residential Crisis Services	<b>Implemented:</b> Billing for the 6 residential beds located in the crisis center is operational.
Access Program Mental Health Assessments	<b>In Progress:</b> DHHS is moving ahead with billing for transitional health services. However, walk-in services are not billed. DHHS estimates that 50% of walk-in clients have or are eligible for Medicaid, but additional questions must be answered before DHHS determines if walk-in billing is feasible.
Crisis Center Mental Health Assessments	<b>In Progress:</b> DHHS is moving ahead with billing for transitional health services. However, walk-in services are not billed. DHHS estimates that 25% of walk-in clients have or are eligible for Medicaid. DHHS to complete assessment of walk-in billing opportunities in the Access Program before deciding whether to bill for walk-in services in the Crisis Center.
Crisis Center Evaluation and Management (E&M)	<b>In Progress:</b> Billing for E&M related to residential crisis services is operational. Billing for E&M transitional behavioral health services has just started.
Substance Use Disorder Assessments (SUD)	<b>Outstanding Questions:</b> While these services are billable, it is difficult to successfully bill for both a SUD Assessment and a mental health assessment provided at the same encounter and the reimbursement for mental health assessments is higher.
Mobile Treatment Services	<b>Rejected:</b> DHHS states that it offers Mobile Crisis Services, not mobile treatment services. Mobile Crisis Services are explicitly included on the Maryland Department of Health and Mental Hygiene (DHMH) non-chargeable list, and thus may not be billed.

**Recommendation 2:**

**In consultation with the CAO, DHHS should determine which of the contractor's recommendations should be implemented and begin billing for those services.**

*Other DHHS Efforts to Increase Medical Billing*

---

In addition to the implementation of the NextGen EHR and the work plan progress summarized above, DHHS informed us it is seeking two changes to the way in which it does business which were not explicitly recommended by the contractor but will provide a framework to better implement recommendations and maximize medical billing revenue.

First, DHHS seeks to amend state regulation to remove a limitation that prohibits providers, including the County, from billing Medicaid for services provided free of charge to other patients. DHHS stated that this specifically applies to Crisis Center services which have been provided free of charge to the public for the past 30 years. DHHS is interested in implementing the Contractor recommendation to bill Medicaid when possible, but does not wish to bill private insurance or charge patients a co-pay for crisis services. DHHS presented documentation that a potential change in regulation that would allow DHHS to seek Medicaid reimbursement for services given at no charge to the general public is being contemplated by the State, but remains in the “gathering comments” stage.

Second, DHHS presented information indicating that in Maryland, Medicaid payments occur through several mechanisms. Payments for some somatic (physical) health services occur through one of several managed care organizations (MCOs). Like other health insurance carriers, the MCOs have “in network” and “out of network” rates of reimbursement for their providers. Because the County does not have a current contract with any of the MCOs, the County is considered an “out of network” provider and typically receives less reimbursement and enjoys less access to support and help from the insurance carrier to work through claim submission problems.

DHHS intends to pursue contracts with the Medicaid MCOs and expects that these contracts will both improve overall reimbursement rates and allow the County to bill for some services that are not covered by Medicaid but are supported by the MCOs themselves.



**Summary and Conclusion:**

Due to the long term trend away from grants toward fee-for-service arrangements in public health and behavioral health programs, DHHS recognized a need to generate additional revenue to maintain service levels. DHHS utilized the services of a contractor to identify opportunities to maximize medical billing revenue. OIG staff reviewed DHHS' implementation of the contractor's recommendations.

We found that the implementation of the NextGen EHR system has allowed DHHS to more fully track the status of medical billing claims and to more easily pinpoint bottlenecks and problems with medical billing. We anticipate that DHHS will continuously utilize the metrics provided by the new system to increase revenue collection and improve employee accountability for the DHHS programs that are currently billing. We recommend that DHHS formalize a plan to hold staff and management accountable for successful medical billing.

In the Crisis Center and Access Program, there are other services provided that can be appropriately reimbursed by Medicaid and/or Medicare but are not currently billed. DHHS hired a contractor to identify such opportunities and the consultant's work concluded over a year ago. Following our initial meeting with DHHS management, an action plan was created to address the contractor recommendations. To date, DHHS has informed us that it is actively exploring the opportunities presented by the contractor, but has fully implemented billing in only one of the recommended areas. We recommend that, in consultation with the CAO, DHHS determine which of the contractor's recommendations should be implemented and begin billing for those services.

In addition, DHHS explained that it is working to secure insurance contracts with the Medicaid MCOs which will allow DHHS to improve reimbursement rates and bill for some items that Medicaid does not cover. Additionally, for Crisis Services, DHHS states that it is pursuing a change in regulation that will allow DHHS to bill Medicaid for Crisis Services but continue to provide services free of charge to other clients who do not have Medicaid coverage. We understand that DHHS plans to continue to diligently pursue both of these options in order to maximize future revenues.

Our recommendations support these DHHS efforts to generate revenue necessary to maintain public health and behavioral health services.

**Summary of the Chief Administrative Officer's Response (CAO):**

The CAO agreed with our findings and recommendations. Nothing in the response caused us to alter our report. The response from the CAO is included in its entirety on the next page.



OFFICE OF THE COUNTY EXECUTIVE

Isiah Leggett  
County Executive

Timothy L. Firestine  
Chief Administrative Officer

MEMORANDUM

November 28, 2016

TO: Edward L. Blansitt, Inspector General

FROM: Timothy L. Firestine, Chief Administrative Officer *Timothy L. Firestine*

SUBJECT: Final Draft Advisory Memorandum: Montgomery County Department of Health and Human Services Healthcare Billing Practices

I am in receipt of your final Draft Advisory Memorandum dated November 21, 2016 detailing the County's Department of Health and Human Services (DHHS) Healthcare Billing Practices. Your principal investigator reached out to DHHS staff to share the preliminary findings and to receive input. DHHS staff provided comments, and the Office of Inspector General (OIG) staff included that input into the final Draft.

We agree with both the findings and the recommendations contained in the final Draft. DHHS has already begun working on many of the proposed recommendations and remains committed to improving its billing practices, while ensuring that access to services for the County's most vulnerable residents remains barrier free.

We also appreciate that your findings and recommendations acknowledge and support the efforts already initiated by DHHS.

Thank you again for your work on this Draft. If you have questions, please contact Fariba Kassiri, Assistant Chief Administrative Officer, at (240) 777-2512 or [Fariba.Kassiri@montgomerycountymd.gov](mailto:Fariba.Kassiri@montgomerycountymd.gov).

TLF:tjk

cc: Fariba Kassiri, Assistant Chief Administrative Officer  
Uma Ahluwalia, Director, Department of Health and Human Services