OFFICE OF THE INSPECTOR GENERAL
MONTGOMERY COUNTY MARYLAND

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DHHS Medical Billing

Department of Health and Human Services

OIG Publication #25-14

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Executive Summary

This follow up audit of the OIG's FY2017 review of the Department of Health and Human Services' (DHHS) efforts to collect payment for medical services provided, was initiated based on complaints to the OIG's hotline alleging continued concerns. The OIG's FY2017 report noted that DHHS should develop a formal plan that holds DHHS personnel accountable to ensure the effectiveness of the medical billing process, and that DHHS should finish implementing billing processes for five services as recommended by a contractor.

We observed improvements with DHHS's billing efforts but also found errors in billings and a lack of systematic protocols to monitor billing processes, without which there is limited assurance that the County is collecting all possible payments. As we did in our FY2017 review, we again noted that DHHS' medical billing policies lack staff training requirements and performance measures to hold staff accountable and thereby ensure the effectiveness of the medical billing process.

Objectives

Through this audit we sought to assess the effect of communicated improvements in response to the OIG's Fy2017 review and changes to billing practices, as well as to evaluate overall billing collection efforts.

Scope and Standards

Our audit covered activity from July 1, 2021 through January 9, 2024 and was conducted in accordance with generally accepted government auditing standards (GAGAS).

Results

DHHS is not maximizing efforts to collect payment for services provided to patients using Montgomery County's Public Health services.

Recommendations

We made 3 recommendations to assist DHHS in increasing revenue collections for the services they provide. Among them are recommendations to develop a formal oversight process for medical claims billing, and implementation of performance measures for staff to increase accountability.

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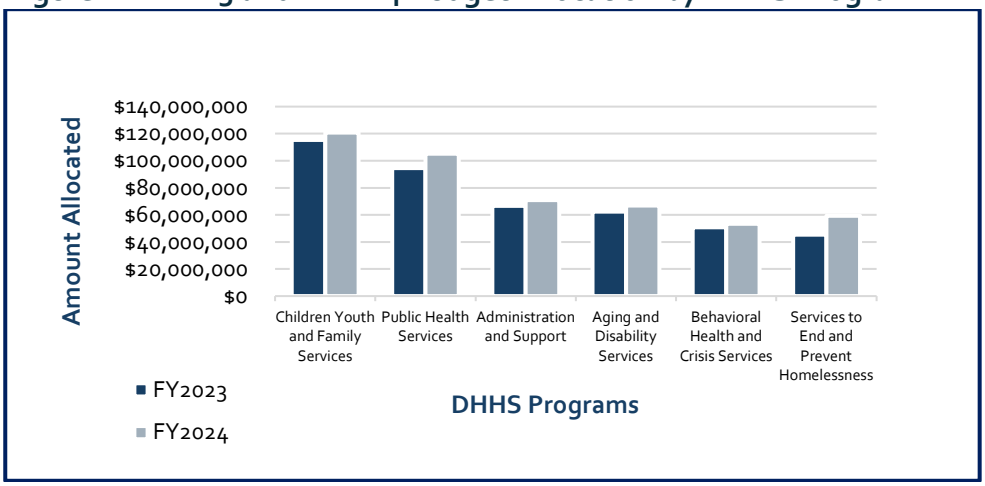
BACKGROUND

The Department of Health and Human Services' (DHHS) mission is to assure the "delivery of a full array of services to address the somatic and behavioral health, economic and housing security, and other emergent needs of Montgomery County residents."[1] To address its mission, the department leverages resources within its six major programs[2] to deliver services at more than 20 locations in Montgomery County.[3] These include providing healthcare resources to protect the community's health, including the health and safety of at-risk children and vulnerable adults, and addressing basic needs such as food, shelter, and clothing.

DHSS's operating budget for fiscal years (FY) 2023 and 2024 was $435,125,666 and $476,410,072 respectively. Figure 1 below displays the budget allocations by DHHS program area.

Figure 1: FY2023 and FY2024 Budget Allocation by DHHS Program



As our audit focused on DHHS' billing practices, we primarily examined activities within the Administration and Support program area. This DHHS program area includes the Office of the Chief Operating Officer (OCOO) which oversees and facilitates various administrative services that support the department's daily operations. Within OCOO, the Revenue, Medical Billing Fiscal team ("Fiscal team") and the Electronic Health Record (EHR) Practice Management team are responsible for the medical billing and payment collection process used by all program locations that offer healthcare services on behalf of DHHS. From FY22 to FY24 medical billing fees and reimbursements accounted for approximately $1.6 million, $1.4 million, and $2 million of general fund revenue respectively. DHHS has used the EHR information system to execute clinical management and medical billing services since 2015. The NextGen system is comprised

[1] Montgomery County MD Operating Budget, DHHS ((https://apps.montgomerycountymd.gov/)
[2] (1) Administration and Support, (2) Aging and Disability Services, (3) Behavioral Health and Crisis Services, (4) Children, Youth and Family Services, (5) Public Health Services, and (6) Services to End and Prevent Homelessness
[3] https://www.montgomerycountymd.gov/hhs/aboutHHS/aboutHHSmain.html

of two interfaces: (1) NextGen Enterprise EHR – where program staff can schedule patient appointments and input patient data, and (2) NextGen Enterprise Practice Management (PM) – where the medical billing process is completed after encounters are finalized in NextGen EHR. NextGen PM is also used for tracking billing activities on a daily and monthly basis.

FY2017 Inspector General Audit

In November of 2016, the Montgomery County Office of the Inspector General (OIG) issued a report related to its audit of DHHS billing practices. In the report, the OIG recommended DHHS develop a formal plan that holds DHHS personnel accountable to ensure the effectiveness of the medical billing process, and they finish implementing billing processes as recommended by a contractor they hired in 2014.

Relevant Budget Developments

DHHS's FY2024 budget was increased by $375,507 to hire additional OCOO administrative staff and increase staff in a coding unit to reduce medical billing errors. As of the field work for this audit, DHHS had not hired permanent staff to fill coder positions but was using contractors to perform coding tasks.

In his FY2025 recommended budget, the County Executive included 11 positions for DHHS and noted the positions, six of which appeared to be related to billing, would generate "at least $1 million in additional revenue." Those 11 positions, however, were not approved in that year's final budget.

OIG Audit Approach

We conducted this performance audit in accordance with generally accepted government auditing standards (GAGAS).

Appendix A contains information on this audit's objectives, scope, and methodology.

FINDINGS AND RECOMMENDATIONS

As was the case with the OIG's FY2017 review, this audit was precipitated by complaints to the OIG's hotline citing concerns that DHHS was missing opportunities to collect for medical services provided. The OIG's FY2017 report noted that DHHS had procured a contractor to maximize medical billing revenue collection and that they had seen some progress in improving collection efforts. Nonetheless, the OIG review found additional areas for improvement. Specifically, that DHHS should develop a formal plan that holds DHHS personnel accountable to ensure the effectiveness of the medical billing process, and that DHHS should finish implementing billing processes for five services as recommended by the contractor.[4]

Through this audit we sought to assess the effect of communicated improvements in response to the OIG's Fy2017 review and changes to billing practices, as well as evaluate overall efficiency of billing collection efforts. We subsequently found improved billing efforts but also errors in billings, and a lack of protocols to monitor billing processes, without which there is limited assurance that the County is collecting all possible payments. Additionally, as in our FY2017 review, we noted that DHHS' medical billing policies lack consistent staff training requirements and performance measures to hold staff accountable and thereby ensure the effectiveness of the medical billing process.

Finding: DHHS is not maximizing efforts to collect payment for services provided to patients using Montgomery County's Public Health services.

Multiple DHHS employees we interviewed acknowledged that DHHS could collect more payments and reimbursements for medical services they provide. According to information provided by DHHS, they incurred chargeable expenses of $21,769,582 in FY2022 and $22,717,913 in FY2023 for medical services provided by the department. However, they subsequently collected only $3,148,033 and $3,150,404 respectively related to those charges for the two fiscal years. This represents a collection rate of 14.2% for both years.

There seemed to be little agreement among the DHHS staff members we interviewed as to the cause or extent of potential issues preventing them from collecting more revenues. Some staff cited poor training of patient-facing program staff leading to them failing to ask patients the correct information needed to bill encounters. Other staff said that categorizing services as non-billable by default was the primary problem. Some staff also pointed to gaps in cross-team communication and collaboration within the medical billing team, which may lead to unclear assignment of responsibilities and a general lack of accountability.

[4] Residential Crisis Services, Access Program Mental Health Assessments, Crisis Center Mental Health Assessments, Crisis Center Evaluation and Management, and Substance Use Disorder Assessments

In following up on a recommendation from our FY17 report, we observed that there is still no consistent measure of performance and accountability applied to all DHHS personnel involved in the medical billing process. In a July 2017 update shared by the County's Internal Auditor, DHHS said they "rolled out a technology component in all FY18 performance plans, both for managers and for front-line staff" and that "training on the new performance plan element was held with all supervisors, and the expectation is that all staff will be held accountable for their performance in this area this year." This initiative appears to have been implemented for one year and the OIG did not see any evidence of DHHS' intent to expand it to future years. Performance metrics and associated plans are critical to enhancing staff performance which in turn will result in reduced errors, and lead to more consistent collection practices.

To identify other opportunities for improvement and evaluate DHHS's billing practices, we analyzed a random sample of 250 out of 7,895 patient visits, or what DHHS refers to as "encounters", from February 2023. Based on the sampling method used, the results of the sample are representative for the entire month of February 2023. Table 1 displays summary details from our sample. The table is separated by how encounters were expected to be paid (Financial Class); the total that DHHS represented could have been billed for these encounters (Total Charges); the total amount of charges that DHHS did not collect (Amount Not Collected), and the total amount of charges that DHHS did collect in payment (Amount Collected).

Table 1: Summary of Charges versus Collected Amounts

Financial Class	Total Charges	Amount Not Collected[5]	Amount Collected
Non-Billable	$27,665.81	$27,665.81	$0.00
Self Pay	$40,214.87	$39,234.87	$980
Medicaid	$2,698.65	$870.88	$1,827.77
Medicare	$298.94	$0.00	$298.94
Care for Kids	$248.41	$243.41	$5.00
Totals	**$71,126.68**	**$68,014.97**	**$3,111.71**

As the table shows, DHHS only collected $3,111.71 (4%) of chargeable expenses in our sample. Extrapolated to the whole month of February, it's expected that DHHS likely collected only $29,221.74 out of $730,543.58 in chargeable expenses.

[5] The term "amounts not collected" refers to medical billing charges that were either waived, e.g., due to a patient's documented inability to pay, or deemed non-billable

We also found that 27 of the 250 encounters we sampled (10.8%, totaling $7,014.97) experienced at least one billing issue that DHHS was unaware of, did not document, and could not determine if the applied adjustment complied with policy. The billing issues included missing medical diagnosis codes; procedures that were "written off" by the County without determining if they could have been covered by insurance; lack of follow-up by DHHS on missing claim decisions from Medicaid; possible improper use of administrative codes that do not charge a rate (instead of codes that do charge a rate); and undocumented patient fee waivers. When generalized to the whole month of February, this means that there were approximately 853 errors totaling approximately $78,899. We also found that about 18% (totaling $2,826.87) of all self-pay encounters in our sample did not have documentation in NextGen to justify why adjustments[6] were applied.

While analyzing these errors, we found that DHHS lacked a viable quality assurance process to ensure medical billing charges and adjustments are being applied appropriately. Further, we observed a need for additional training, particularly more consistent training for program location staff and training on coding related to medical billings. Absent proper oversight of medical billing processes and consistent staff training, DHHS is not able to prevent and correct immediate and systemic issues that lead to a loss of revenue.

DHHS budget requests for FY2024 and FY2025 reflect a recognition that more staffing could provide opportunities for increased collections. However, additional staffing will only produce greater results if coupled with process improvements as well. With that in mind, DHHS should increase oversight of the medical billing process, increase training, and further institute performance metrics to hold staff accountable. These efforts should lead to increased revenue collection for the County while still providing the same full range of services.

Recommendations

We recommend DHHS:

1) **Develop and implement a formal written quality assurance process to ensure medical billing charges and adjustments are being applied appropriately.**
2) **Implement performance measures for all staff involved in the medical billing process to strengthen accountability and minimize errors.**
3) **Memorialize staff training requirements into policy and monitor participation to ensure better compliance with policy and procedures.**

[6] According to DHHS, self-pay adjustments occur when patients' bills are waived by program managers of the DHHS program locations at their discretion and for hardship reasons.

OIG Comments to Chief Administrative Officer Response

The County Chief Administrative Officer's response to our report is included in its entirety in Appendix B. The response indicates compliance with the OIG's recommendations. Appendix C summarizes the CAO's response to our recommendation and the OIG's assessment of the County's progress towards fully implementing the stated action.

APPENDIX A: OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of this performance audit were to:

1) Determine the extent that recommendations documented in the November 30, 2016, Final Advisory Memorandum #17-002, were implemented.
2) Evaluate HHS's efforts to collect on billed amounts for patient care.

Scope and Methodology

The scope of our audit covered various subject areas outlined below for the period of July 1, 2021, through January 9, 2024:

- All healthcare claims billed, and revenues collected for services rendered.
- Any documented internal procedures for the receiving and processing of revenue that were applicable during the scope period.
- All inputs and outputs (i.e., reports) for the NextGen Electronic Health Record system and all its capabilities for the healthcare claims billing process.
- Listing of all providers that worked with DHHS and their billable and non-billable services during the scope period.

From January 2024 to May 2024, we conducted fieldwork to achieve our stated objectives. We conducted interviews and walkthroughs to gain an understanding of the billing and revenue collection processes, reviewed DHHS internal policies and procedures related to billing and collections and obtained access to the NextGen system to test billed encounters. We also reviewed applicable County policies and procedures before sampling encounters to test against criteria.

We obtained and reviewed the following criteria for our performance audit:

1) Applicable DHHS Standard Operating Procedures related to medical billing and cash receipt procedures
2) DHHS Fee Collection Policy, dated November 15, 2012[7]
3) DHHS internal policies and procedures for the processing of claims in NextGen
4) Recommendations per OIG Final Advisory Memorandum #17-002, dated November 30, 2016
5) 2024 Maryland Medical Assistance Program Professional Services Provider Manual, effective January 2024
6) Maryland Department of Health FY23 Current Procedural Terminology and rates

[7] The Fee Collection Policy was updated on January 9, 2024, to include changes in technology and processes related to the NextGen system, to include changes in technology and processes related to the NextGen system.

7) Maryland Department of Health – FY23 Local Health Department Non-Chargeable List
8) Applicable sections of the Code of Maryland Regulations (COMAR), Title 10, Maryland Department of Health
9) Montgomery County MD Department of Finance, Accounts Receivable Policies, effective April 1, 2020

Objective 1 – Implementation of Previous Recommendations

To determine if recommendations from the OIG Final Advisory Memorandum #17-002 were implemented, we reviewed the memorandum and conducted interviews with DHHS personnel to determine if they were aware of the recommendations and to gain an understanding of the progress that has been made since the issuance of the memorandum. We reviewed internal reports and obtained a status report from the County's Internal Audit Manager to evaluate if recommendations from the previous memorandum were implemented.

Additionally, we obtained a listing from DHHS that included the number of encounters and amounts billed from FY2016 to FY2023 to determine if the recommended services had been expanded and implemented. We were informed that DHHS rejected one service from the originally suggested services, leaving five from the memorandum to be included. The list contained encounters and amounts billed for the five services; however, it did not include any corresponding revenues that had been collected for these services. As a result, we were unable to verify if revenues were in fact collected for the expanded services.

Objective 2 – Efforts to Collect on billed amounts

To evaluate DHHS's efforts to collect billed amounts, we assessed the design and implementation of controls over healthcare claims billing. Through observation and inquiry, we learned that there was a high volume of encounters during our scope period; therefore, we determined that our population of encounters should include only one month of patient visits. We judgmentally selected February 2023 as the month to sample and obtained a listing from DHHS of all encounters in February 2023. The February 2023 list contained 7,895 unique encounters. We randomly selected 250 encounters for testing by utilizing the risk-based sampling approach for substantive testing noted in table 2.

Table 2: Risk-based Sampling Methodology

Number of Transactions in Population	Percentage of Items to Test (based on risk)
<100	100%
101-500	Low: 20% Medium: 30% High: 40%
501-900	Low: 10% Medium: 15% High: 20%
901-1,800	Low: 5% Medium: 8% High: 10%
>1,800	Low: 1% Medium: 3% High: 5% (limit to 250 items)

We determined the risk related to controls over healthcare claims billing to be high due to multiple factors including complaints received, previous related recommendations going unresolved, and a lack of formal protocols to monitor the billing process. OIG standard is to limit testing to 250 items; as a result, we utilized data analysis software to randomly select 250 encounters for testing.

After sampling, we gained access to the NextGen system to test each selected encounter. Testing included analyzing claims to determine the outcomes of services provided and the related charge amount to be paid. We reviewed the encounter's individual charge amount, the total amount billed, and whether the encounter has been fully paid or adjusted for non-billable services. We also determined whether the amounts were billed or charged to insurance or to the patients. Finally, we sought to determine whether the encounter was fully closed or remained open.

Internal Controls

We evaluated DHHS's internal controls and compliance with policies and procedures related to the review and approval of speed camera invoices. However, we did not assess DHHS's internal control structure to provide assurance on its effectiveness. We conducted walkthroughs, interviews, and documentation reviews to assess whether internal controls related to the design of appropriate types of control activities, separation of duties, and documentation of responsibilities through policies are properly designed and implemented. It is important to note that our review was limited in scope and may not have identified all internal control deficiencies that may have existed at the time of this audit.

Auditing Standards

We conducted this performance audit in accordance with generally accepted government auditing standards (GAGAS). Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: CHIEF ADMINISTRATIVE OFFICER (CAO) RESPONSE

The Chief Administrative Officer provided the following response to our report:

OFFICE OF THE COUNTY EXECUTIVE

Marc Elrich
County Executive

Richard S. Madaleno
Chief Administrative Officer

MEMORANDUM

May 29, 2025

TO: Megan Davey Limarzi, Inspector General

FROM: Fariba Kassiri, Deputy Chief Administrative Officer

SUBJECT: Inspector General Confidential Draft Report: Department of Health and Human Services (DHHS) Medical Billing (OIG Publication #25-14)

Thank you for the opportunity to respond to the issues identified in the Office of Inspector General's (OIG) follow-up audit of the OIG's Fiscal Year (FY)17 review of the Department of Health and Human Services' (DHHS) effort to collect payment for medical services provided.

While medical billing by the Department of Health and Human Services (DHHS) is not a requirement written in Code of Maryland Regulations (COMAR) or County law or regulations, in 2004, DHHS implemented a new electronic health record, specifically NextGen. At that time, it was the intent of the Department to create a single record for medical and behavioral health programs, allowing for continuity of care and to begin electronically billing for services. While most clients seen in our clinics are uninsured (85.7%), money is either not collected due to State-required "non-billable services," is collected as self-pay on a sliding scale, or is not collected due to financial hardship. However, only 13.5% of our clients have Medicaid or Medicare, and less than 1% have private insurance, and that is where we can maximize our billing through accurate insurance claims. However, it is our charge to serve as a safety net for residents without access to care. With current funding and the number of professional service providers, any efforts to increase the number of insured clients just to increase revenue risks creating a wait list for uninsured clients.

But we continue to improve, and every year since implementation, we have increased the revenue received through medical billing. In FY24, the total from all sources (insurance to self-pay) was $1,679,630. In FY25, we requested 6 additional infrastructure positions to help with improving data entry accuracy and coding to improve reimbursement outcomes.

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We acknowledge that there are opportunities to improve DHHS' medical billing process. As noted below, we are committed to taking appropriate steps to address the report's findings and recommendations.

Recommendation 1: We recommend the DHHS develop and implement a formal written quality assurance process to ensure medical billing charges and adjustments are being applied appropriately.

DCAO Response. We concur with this recommendation. During the past several years, DHHS has focused on improving coding of encounters to maximize reimbursement amounts but has spent far less effort on quality assurance and encounter documentation. A plan to separate quality assurance from the actual billing actions has already been started to allow encounter audits and review to occur, and shared with staff and supervisors instead of waiting for billing errors to show up in rejected claims to be fixed on the back end. A formal plan is being drafted and is expected to be completed by August 31, 2025.

Recommendation 2: We recommend the DHHS implement performance measures for all staff involved in the medical billing process to strengthen accountability and minimize errors.

DCAO Response. We concur with this recommendation. Several years ago, a new appraisal objective was created, "Use of IT Systems," which was rolled out to all staff across DHHS to capture how staff use IT and to hold them accountable for using those systems as part of their job. DHHS has spent significant time getting supervisors to include this objective, but its application in mid-year and annual evaluations has led to mixed results. DHHS Senior Leadership has embarked on monthly meetings with all supervisors where accountability is part of each discussion. It is hoped that with the implementation of the Quality Assurance Plan, this will assist supervisors in assessing staff work product in the electronic health record, which will significantly decrease documentation errors that lead to lower billing revenues.

The objective below was provided to supervisors more than 5 years ago and is expected to be in all employee appraisals at all levels of DHHS:

- Identify the DHHS electronic record systems used by you and your staff and ensure consistent use of those systems as related to their daily work. Use sign-on reports to monitor use of the systems by your staff and address use issues as they arise.

- Utilize IT system reports to make decisions about budgeting, staffing, programming, and staff evaluations. Identify and use data sources for reporting for grants, budget measures, outcome measures, Chief's Report, etc.

- Monitor, read, and respond to Outlook emails in a timely manner, including answering constituent requests and resolving constituent concerns when requested.

- Utilize Microsoft Office applications, including Word, Excel, and PowerPoint, to complete daily tasks and letters, budget requests, data requests, and presentations as requested.

- Complete all online cybersecurity trainings each month on time.

Recommendation 3: We recommend the DHHS memorialize staff training requirements into policy and monitor participation to ensure better compliance with policy and procedures.

DCAO Response. We concur with this recommendation. DHHS has already begun examining the best way to deliver training and identifying the most appropriate topics that will help improve medical billing and meet Quality Assurance measures. A formal policy for medical billing training will be drafted and implemented no later than August 31, 2025.

Your report's findings and recommendations will be useful as we continue to improve DHHS' medical billing processes. Thank you for bringing these matters to our attention.

cc: Dr. James Bridgers, Director, Department of Health and Human Services
Mark Hodge, Chief Operating Officer, Department of Health and Human Services
Maxene Bardwell, Internal Audit Manager, Office of the County Executive

APPENDIX C: RECOMMENDATION STATUS AND FOLLOW UP

This Appendix provides a summary of the findings and recommendations presented in this report along with the OIG's assessment of the county's progress towards addressing the recommendations. The OIG categorizes progress towards implementation into the following 4 status groups:

- Open Unresolved: No management response, inadequate response, or no agreement on corrective action plan.
- Open In Progress: Agreed on planned action, auditee is in the process of implementing stated actions, but no evidence of implementation has yet been provided to the OIG.
- Open Resolved: Auditee provided support to OIG indicating implementation was complete, OIG testing to ensure implementation.
- Closed: Recommendation has been implemented.

Finding #	Finding	Recommendation	CAO Response	Status
1	DHHS is not maximizing efforts to collect payment for services provided to patients using Montgomery County's Public Health services.	**We Recommend HHS:** (1) Develop and implement a formal written quality assurance process to ensure medical billing charges and adjustments are being applied appropriately.	We concur with this recommendation. During the past several years, DHHS has focused on improving coding of encounters to maximize reimbursement amounts but has spent far less effort on quality assurance and encounter documentation. A plan to separate quality assurance from the actual billing actions has already been started to allow encounter audits and review to occur, and shared with staff and supervisors instead of waiting for billing errors to show up in rejected claims to be fixed on the back end. A formal plan is being drafted and is expected to be completed by August 31, 2025.	Open – In Progress

Finding #	Finding	Recommendation	CAO Response	Status
		We Recommend HHS: (2) Implement performance measures for all staff involved in the medical billing process to strengthen accountability and minimize errors.	We concur with this recommendation. Several years ago, a new appraisal objective was created, "Use of IT Systems," which was rolled out to all staff across DHHS to capture how staff use IT and to hold them accountable for using those systems as part of their job. DHHS has spent significant time getting supervisors to include this objective, but its application in mid-year and annual evaluations has led to mixed results. DHHS Senior Leadership has embarked on monthly meetings with all supervisors where accountability is part of each discussion. It is hoped that with the implementation of the Quality Assurance Plan, this will assist supervisors in assessing staff work product in the electronic health record, which will significantly decrease documentation errors that lead to lower billing revenues.	Open – In Progress

Finding #	Finding	Recommendation	CAO Response	Status
		We Recommend HHS: (3) Memorialize staff training requirements into policy and monitor participation to ensure better compliance with policy and procedures.	We concur with this recommendation. DHHS has already begun examining the best way to deliver training and identifying the most appropriate topics that will help improve medical billing and meet Quality Assurance measures. A formal policy for medical billing training will be drafted and implemented no later than August 31, 2025.	Open – In Progress