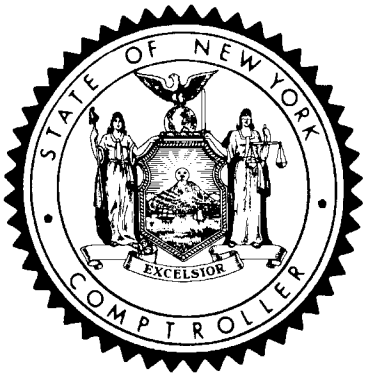
State of New York
Office of the State Comptroller
Division of Management Audit and State Financial Services

OFFICE OF MENTAL HEALTH

CONTROLS OVER OUTPATIENT BILLINGS

REPORT 99-S-31



H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit and State Financial Services

Report 99-S-31

Mr. James L. Stone, M.S.W.
Commissioner
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Dear Mr. Stone:

The following is our audit report on controls over outpatient billings at six selected OMH facilities.

This audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law. Major Contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit
and State Financial Services

July 31, 2000

Executive Summary

Office of Mental Health Controls Over Outpatient Billings

Scope of Audit

As part of its integrated system of mental health care, the Office of Mental Health (OMH) provided outpatient services to an average of 12,700 outpatients per month during the 1998-1999 fiscal year at its mental health facilities throughout the State. The cost of these services is reimbursable by Medicaid, Medicare and third party health insurers. For outpatient services to be reimbursable, they must be provided through a licensed program by appropriate personnel, and be identified and provided in accordance with an approved individual plan of treatment. When clinicians provide outpatient services, they are supposed to record a progress note in the patient's medical record and enter visit data on a service recording form. Facility clerical staff enter data from the service recording form onto a service recording subsystem of the Department of Mental Hygiene Information System (DMHIS), which contains patient demographic and service data. OMH Central Office staff upload facilities' visit billing data to OMH's Comprehensive Outpatient Billing System (COBS), where it is aggregated into billable visits and submitted to insurers for payment. For the State fiscal year ended March 31, 1999, OMH reported collecting $31.6 million in revenues from outpatient services, most of which was paid by Medicaid ($20.9 million) and Medicare ($10.2 million).

Our audit addressed the following question about OMH's controls over billing for outpatient services for the period April 1, 1998 through March 31, 1999:

- Does OMH adequately document, accurately record and submit appropriate and timely bills for the outpatient services provided at OMH facilities?

Audit Observations and Conclusions

Our audit found that OMH needs to improve procedures at its facilities to increase the likelihood that reimbursement is obtained for services provided to outpatients. At the six facilities we visited, some billed services were not documented in the patients' medical records and other services were not billed, because clinicians did not record or staff did not correctly enter data on to DMHIS. We also found significant variance in the time it takes facilities to submit bills to insurers, with 9 of 24 facilities averaging over 90 days from the date of the outpatient visit to the date the bill was submitted for payment.

For six OMH facilities, we selected a random sample of 300 outpatient visits (50 at each facility) from the COBS database to determine whether clinicians had entered progress notes in patients' medical records, as required by OMH rules and regulations. We found that 22 (7 percent) of the 300 billed visits,

representing $3,234 (8 percent) of the total sample billing of $41,851 were not documented in the patients' medical records. (See pp. 5-6)

We also selected a judgmental sample of 287 outpatient visits (we excluded 13 that were not on a fee for service plan) from the medical records of the same patients selected in the first sample, to determine whether these visits were properly billed to insurers. We found that the six facilities did not bill for 33 visits (11 percent) for the dates shown in the patients' medical records; one facility did not bill 16 percent of the visits we sampled. From available billing data, we were able to estimate that the total amounts for 28 of the 33 unbilled visits was $4,168 or 12 percent of the total billed for this sample. (See pp. 7-8)

Clinicians should include necessary billing information for outpatient services, such as the duration of the visit and the type of service, in the patients' medical records as well as maintaining the service recording forms. However, we found that not all the facilities consistently maintain these forms for the six-year statutory period. From our review of the patients' medical records for visits in both samples at four of the six facilities, we found that essential billing information such as the duration of visit was missing for 25 percent of the documented visits. (See pp. 8-10)

Bills for services should be submitted for payment in a timely fashion to avoid potential disallowances and loss of revenue. We analyzed the COBS database for all 349,880 outpatient visits that occurred between April 1, 1998 and March 1, 1999, to determine the time that elapsed between the visit date and the initial billing date. Our analysis showed that facilities' billing time ranged from 16 to 630 days. Further, 107,059 bills (31 percent) were submitted more than 90 days after the visit date; of these, 5,205 were submitted more than a year after the visit date. (See pp. 12-13)

To reduce the risk that insurers will disallow payment for outpatient visits, we recommend that OMH take steps to ensure clinicians document services, including data needed for billing, in patients' medical records and on service recording forms, and establish procedures to verify the accuracy of data entered on the billing system. We also recommend that OMH investigate billing variances among facilities and take steps to ensure that facilities submit bills promptly.

Comments of OMH Officials

In their response to the draft report, OMH officials stated that they generally agreed with the report's observations and recommendations to improve controls for outpatient billings. They also stated that adequate documentation in the patient records continues to be a focus of OMH efforts. A complete copy of OMH's response is included as Appendix B to this report.

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Analysis of COBS Database
Days Taken to Submit Bills for Outpatient Visits

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Major Contributors to This Report

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Response of Office of Mental Health Officials

Introduction

Background

The Office of Mental Health (OMH) is responsible for the planning and operation of an integrated system of mental health care designed to assist adults who have serious and persistent mental illness and children who suffer from serious emotional disturbances. OMH provides inpatient, outpatient and community support programs in its facilities throughout the State.

OMH reported that it provided outpatient services to an average of about 12,700 outpatients per month during the 1998-1999 fiscal year. The cost of these services is generally paid by Medicaid, Medicare and third party health insurers. Parts 587 and 588 of the New York Codes, Rules and Regulations deal with reimbursement rates and any eligibility criteria for patients who receive outpatient services. For outpatient services to be reimbursable, they must be provided through a licensed program. Services must also be identified and provided in accordance with an approved individual plan of treatment. For the State fiscal year ended March 31, 1999, OMH reported collecting $31.6 million in revenues for outpatient services it provided. Medicaid and Medicare reimbursed $20.9 million and $10.2 million of these costs, respectively.

OMH facility procedures require that clinicians who provide an outpatient service should note data about the visit in the patient's medical record and also on a clinical service recording form. A facility employee then enters the outpatient service information (including the case number, service date, service unit, program and service codes, service duration and staff providers) shown on the service recording form into the service recording subsystem of the Department of Mental Hygiene Information System (DMHIS). This subsystem allows for corrections to and validation of service-related data before this data is uploaded to DMHIS, which contains OMH patient demographic and service information. Staff in OMH's Central Office in Albany transfer this data from DMHIS to OMH's Comprehensive Outpatient Billing System (COBS). COBS aggregates valid services into daily visits and verifies that a billing account has been established for the patients who received the services. After OMH staff ensure that billing criteria are met, they bill the appropriate insurer. OMH's Patient Resource Offices handle third party health insurance (other than Medicaid and Medicare) and private party denials.

Audit Scope, Objective and Methodology

We audited OMH controls over billing for outpatient services for the period April 1, 1998 through March 31, 1999. The objective of our financial-related audit was to determine whether OMH adequately documents, accurately records and appropriately and timely bills insurers for these services. To accomplish our objective, we reviewed documentation and/or billing for outpatient services for samples of patient visits at six OMH facilities. We judgmentally selected six facilities that reported outpatient revenues of more than $1.5 million (Creedmoor, Elmira, Queens Children's, Rockland, Rockland Children's and South Beach Psychiatric Centers) from among the 24 OMH facilities that reported outpatient revenues during our audit period.

At each of the six facilities, we selected a random sample of 50 outpatient visits (for a total sample size of 300 visits) from the COBS database of outpatient visits that were billed during the period April 1, 1998 through March 31, 1999. The total population of outpatient visits at these facilities for this period was 151,269, as follows: Creedmoor (18,072); Elmira (18,651); Queens Children's (20,056); Rockland (24,914); Rockland Children's (19,757); and South Beach (49,819). OMH personnel performed the sample selection under our supervision. For each visit, we analyzed the patient's medical record to determine if the billed visit was adequately documented.

For another sample, we judgmentally selected an outpatient visit during the period April 1, 1998 to March 31, 1999 from the medical record of each of the same 50 patients selected in the first sample at each facility to determine if services provided, according to the patient's medical record, were accurately recorded on COBS and properly billed. Facility personnel assisted us in identifying billable visits. (The second sample at several of the facilities comprised fewer than 50 visits because the visits we had selected occurred on dates when the patient was enrolled in a pre-paid managed care plan.) Moreover, we could not determine the total population of billable visits for our audit period from patients' medical records.

For the sampled visits at four of the six facilities, we examined the patients' medical records to determine whether they contained the type of service and duration of service information needed to document that OMH billed the proper amount for the service. We excluded Queens Children's and Rockland Children's from this review because, according to OMH officials, in children's day treatment programs, the default duration is a full school day (five hours or more) and that weekly progress notes summarize the services provided.

We performed a limited general and application control review of COBS to determine the accuracy and reliability of the system's data. Using computer assisted audit techniques, we also analyzed the COBS database for all outpatient visits (349,880) that occurred between April 1, 1998 through March

31, 1999, to determine the amount of time that elapsed between the date of visit and initial billing. In addition, we interviewed facility and Central Office officials and reviewed relevant laws, regulations, policies and procedures.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those OMH operations included within the audit scope. Further, these standards require that we understand OMH's internal control structure and its compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach to select activities for audit. We focus our audit efforts on those activities we have identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, we use finite audit resources to identify where and how improvements can be made. We devote little audit effort reviewing operations that may be relatively efficient or effective. As a result, we prepare our audit reports on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of OMH Officials to Audit

We provided draft copies of this report to OMH officials for their review and comment. Their comments were considered in preparing this report and are included as Appendix B.

In their response to the draft report, OMH officials stated that they generally agree with the report's observations and recommendations to improve controls for outpatient billings. They also stated that adequate documentation in the patient records continues to be a focus of OMH efforts and that OMH is in the process of deploying an Electronic Medical Record, to automate data in the medical record and add electronic features such as triggers, alerts, scheduling and service reporting.

Additionally, OMH officials stated that the draft report does not reflect the positive results of our review concerning the billing practices at Hutchings PC and controls over the Comprehensive Outpatient Billing System (COBS) in Central Office. While OMH officials recognized our policy regarding exception based reporting, as stated above in the Audit Scope, Objective and

Methodology section, they requested that we include comments in the final report concerning where the billing system was performing well.

As OMH officials correctly recognize, we state in our audit reports that we employ a risk-based approach to select activities for audit and we devote little audit effort to reviewing operations that may be relatively efficient or effective. However, when we exclude an activity from review based on our preliminary assessment that it presents a relatively low risk, such as billing practices at Hutchings PC, it does not mean that the activity is actually functioning efficiently or effectively. Hence, we do not routinely recognize such activities in our reports. However, we have amended our report to indicate that adequate controls were in place over the COBS system. We also clarified our report for the matters OMH officials brought to our attention under the section of their response titled OMH Comments to Specific OSC Findings and Observations.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office of Mental Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Controls Over Outpatient Billing

We found that OMH needs to strengthen controls over outpatient billing at its facilities, to increase the likelihood that it will obtain reimbursement for services OMH facilities provide. We selected samples of outpatient visits at six facilities and found that some visits billed to insurers were not adequately documented in patients' medical records, and that other visits were not billed. Further, from our review of patients' medical records corresponding to the visits we sampled, we found that an essential element of billing information, the duration of the visit, was missing for 25 percent of the sampled documented visits.

In response to our preliminary audit findings, OMH officials stated that there were several instances where there were errors made in the dates of the progress notes or in the billing dates, and as such, these errors should not be considered as "undocumented" or "unbilled." (We revised our findings with respect to these documentation errors, but reiterate that the facilities should strengthen their procedures to ensure that these types of errors do not continue to occur.) OMH officials replied that adequate documentation in the patient record continues to be a focus of OMH efforts. Toward this end, OMH is in the process of deploying an Electronic Medical Record (EMR), which automates the data in the medical record and adds features such as triggers, alerts, scheduling and service reporting. Furthermore, OMH expects to implement EMR in phases with completion during 2001.

Billed Visits Not Documented

Part 587.18 of the New York Codes, Rules and Regulations require that facilities maintain a complete case record (medical record) for each patient admitted to an outpatient program. In addition to other information, the case record must contain progress notes which relate to the goals and objectives of the patient's treatment plan. In clinic treatment programs, progress notes must be written after every patient visit; in day treatment programs, the notes must be written at least weekly; and in continuing day treatment programs, the notes must be written at least every two weeks. These notes provide the supporting documentation for all visits that are billed. Facilities run the risk that undocumented billings will be disallowed by third-party insurers.

We performed a limited general and application control review of COBS to determine the accuracy and reliability of the system's data. Our review found that adequate controls were in place. As a result, we selected a random sample from the COBS database of 50 outpatient visits at each of 6 facilities, resulting in a total sample size of 300 outpatient visits, to determine whether OMH facilities maintain adequate documentation of outpatient visits in patients' medical records. From our review, we found that 22 of the 300

billed visits (7 percent) were not documented in the patients' medical records. The exceptions ranged from zero percent at Elmira and South Beach to 16 percent (8 of 50) at Creedmoor and Queens Children's. The 22 exceptions represented $3,234 of the $41,851 billed (8 percent) for the outpatient visits we sampled.

In addition, there were five billed visits that were not supported by any progress notes in the patients' medical records for the corresponding billed dates. The amount billed for these five visits totaled $840. According to OMH officials, these visits occurred, but incorrect dates were recorded either in the progress notes or on the billing system. For example, at Rockland Psychiatric Center, a clinician delivered an outpatient service on April 27, 1998 and made a progress note in the patient's medical record for that date. However, the clinician mistakenly entered April 29, 1998 as the visit date on the service recording form. As a result, the bill generated for the April 29 visit was undocumented (because it did not occur) and the actual visit on April 27 was not billed.

The following table shows the number of undocumented visits we noted at each facility and the amount that was billed for them.

Table 1: Number of Undocumented Visits at Six Facilities

Facility	Sample Size	Number of Undocumented Visits	Percent of Visits Sampled	Total Amount Billed	Amount of Undocumented Visits	Percent of Amount Billed
Creedmoor	50	8	16%	$7,673	$1,292	17%
Elmira	50	0	0%	6,183	0	0.%
Queens Children's	50	8	16%	7,233	1,167	16%
Rockland	50	3	6%	7,827	448	6%
Rockland Children's	50	3	6%	6,860	327	5%
South Beach	50	0	0%	6,075	0	0%
Total	300	22	7%	$41,851	$3,234	8%

Services Provided But Not Billed

To help offset the cost of operations, OMH must ensure that it seeks reimbursement for all the billable services its facilities provide. To determine whether the six facilities in our sample billed for all the outpatient services clinicians delivered, we examined a judgmental sample of outpatient visits which we selected from the medical records of each of the patients included in our earlier random sample. With the assistance of facility personnel, we selected billable services that occurred during the period April 1, 1998 through March 31, 1999. Our sample (287 outpatient visits in all) did not total 50 visits at some facilities because we excluded those visits that we subsequently determined were reimbursed through a pre-paid managed care plan. We then checked to see if OMH billed for the visits in this sample.

We found that 33 of the 287 sampled visits (11 percent) were not billed. The highest rates of unbilled visits were at Elmira (16 percent) and Rockland (14 percent). For 28 of the 33 exceptions, we were able to estimate the amounts that should have been billed for these visits from information recorded in progress notes in the patients' medical records and information from the Patient Resource Office. This data included the duration of the visit, the type of service and the type of medical coverage the patient had. As a result, we estimated that OMH should have billed an additional $4,168 (12 percent of the billed amount of $35,713) for the outpatient visits in our sample. In addition, there were three sampled visits that were not billed for the dates indicated in the patients' medical records. According to OMH officials, these visits were billed, but incorrect dates were entered on the billing system.

The following table shows the number of visits we sampled and the number of unbilled visits we noted at each facility. It also shows the number of unbilled visits that we were able to estimate the amount that should have been billed. We could not estimate amounts that should have been billed for the remaining five exceptions we found, since essential billing information (e.g., the duration of the service and/or the type of service in the medical record progress notes) was missing for these visits.

Table 2: Number of Unbilled Visits at Six Facilities							
Facility	**Sample Size**	**Number of Unbilled Visits**	**Percent of Visits Sampled**	**Total Amount Billed**	**No. of Unbilled Visits Estimated**	**Estimated Amount (Unbilled Visits)**	**Percent/ Total Amount Billed**
Creedmoor	**48**	**5**	**10%**	**$6,738**	**5**	**$930**	**14%**
Elmira	**45**	**7**	**16%**	**5,236**	**7**	**980**	**19%**
Queens Children's	**50**	**6**	**12%**	**5,927**	**4**	**560**	**9%**
Rockland	**50**	**7**	**14%**	**6,555**	**4**	**657**	**10%**
Rockland Children's	**48**	**4**	**8%**	**6,090**	**4**	**560**	**9%**
South Beach	**46**	**4**	**9%**	**5,167**	**4**	**481**	**9%**
Total	**287**	**33**	**11%**	**$35,713**	**28**	**$4,168**	**12%**

These unbilled visits occurred either because clinicians did not record the visit on the service recording form or because clerks made data entry errors. These data entry errors can include both mistakes in recording information on the service recording document (e.g., the clinician may write an incorrect entry) and clerical mistakes made in entering service data on the service recording subsystem. For example, at Rockland Children's Psychiatric Center, two of the four services that were not billed were not recorded on any of the service recording documents by the clinicians who provided the services; the other two services were on the service recording documents, but were not entered onto the service recording subsystem. Also, for an exception which occurred at South Beach, the visit was recorded on the service recording subsystem, but COBS did not generate a bill for the visit. In response to our preliminary audit findings, OMH officials agreed that this visit was not billed because there was no attending physician recorded in DMHIS for a part of February 1999.

Information Missing in Patients' Medical Records

When clinicians provide a service, they are supposed to record the visit's service data on a service recording form (billing document) so it can be entered on DMHIS, which is then uploaded on to COBS for billing purposes. In addition, Part 587.18 of the Regulations requires that a complete case record (medical record) be maintained for each person admitted into an outpatient program, and that such medical record shall contain progress notes which relate to the goals and objectives of the patient's treatment plan, the date of all on-site and off-site face-to-face contacts with the recipient, the type of service provided and the duration of contact.

Initially, we were told that the service recording forms are not always kept on a "permanent" basis. Therefore, to determine whether relevant billing data, such as the type of service provided and the duration of the service, are maintained as a permanent record, we examined the patients' medical records for progress notes corresponding to all 389 visits from both our samples of outpatient visits at four of the six facilities. According to OMH officials, in children's day treatment programs, the duration of a full day treatment visit, the school day, is the default duration of five hours or more, and only less-than-full-day visits are documented as such in the progress notes. Therefore, it is not necessary to indicate the duration of the service in the medical record unless it was less than a full day. Also, weekly progress notes also include comments that summarize services which directly correspond to the service codes. Accordingly, we excluded Queens Children's and Rockland Children's Psychiatric Centers from this review.

We found that a critical piece of information needed to determine the proper billing amount, the duration of the service, was missing from the patients' medical records. Table 3 below shows the number of visits we reviewed from both samples where the duration of the service was not recorded in the patients' medical records. For this test, we reviewed a total of 373 outpatient visits (389 total sample visits less the 16 sampled billed visits that had no progress notes for the corresponding billed dates).

Table 3: Number of Visits Missing Duration of Service in Progress Notes

Facility	Combined Sample of Visits Reviewed (Less Undocumented Bills)	Number of Visits Missing Duration of Service
Creedmoor	**87**	**11**
Elmira	**94**	**42**
Rockland	**96**	**29**
South Beach	**96**	**11**
Total	**373**	**93**

From our review, we found that for 93 of the 373 sampled visits (25 percent), the duration of service was not indicated in the patients' medical records progress notes. In this regard, OMH officials stated that all facilities are supposed to maintain billing documents such as the service recording forms for a period of six years, as required by State law. However, they indicated that not all of the facilities we visited consistently maintained the billing documents for the six-year period. They also agreed that the duration of service should be in the patients' medical records as required by law. We found that only one of the six facilities (Creedmoor) did

not retain the appropriate service data as required. In fact, Creedmoor officials indicated that they did not keep the service recording forms beyond six months.

OMH officials replied that prior to full implementation of the Electronic Medical Record, OMH facilities have already or will take corrective action to implement our recommendations. For example, Creedmoor has initiated daily clinical audits to ensure accuracy and completeness and clinicians have been instructed to prepare progress notes and turnaround documents immediately after each billable visit. Also, Rockland is planning training/instructional sessions in the Summer 2000 to address billing and documentation concerns, and expects to complete these sessions by Fall 2000. Also, service directors have begun random reviews of patient records to specifically check for progress notes and related service recordings, and that the Utilization Review form was also amended to include a section to address the timeliness of progress notes, duration of service and outcomes. The officials further replied that in November 1999, Queens Children's developed a structured progress note to ensure that all billable services were accurately recorded on a weekly basis; that Rockland Children's and Elmira are also planning corrective actions to improve their outpatient billing processes; and South Beach has taken action to enhance its procedures for documenting services provided and processing outpatient billings.

Recommendations

1. Take steps to ensure that clinicians accurately document in patients' medical records the outpatient services they provide, including date of service and duration of service.

2. Take steps to ensure that outpatient services are appropriately billed, including that clinicians complete service recording forms for all visits, and that clerical staff enter all visit data on the DMHIS service recording subsystem.

Recommendations (Cont'd)

3. Establish procedures to verify that data entry is performed accurately.

   (Regarding recommendations 1-3, OMH officials replied that the implementation of the Electronic Medical Record (EMR) provides OMH with functions which will greatly assist in ameliorating the conditions identified in the audit. As a result of these features, OMH believes EMR will assist in reducing errors related to insufficient documentation and services provided but not billed.)

4. Take steps to ensure that all facilities retain billing documents, such as the service recording forms, for the statutorily-required period.

   (OMH officials replied that they are in the process of reviewing OMH record retention policy for all documents in conjunction with the State Education Department, which is responsible for such State policies. Also, OMH will take action to ensure that the appropriate documentation to support the services provided and submitted for reimbursement is being retained according to the retention period specified in regulations and/or policy.)

Analysis of the COBS Database

Long delays in billing for services reduce cash flow and increase the risk for potential disallowances and lost revenues. According to OMH officials, Medicaid regulations stipulate that bills should be submitted within 90 days of the visit date, but allow up to two years due to unusual circumstances.

To find out how long it took OMH to bill insurers for services, we obtained a download from the COBS database of all outpatient visits (349,880) that occurred during the period April 1, 1998 through March 31, 1999 at all OMH facilities. According to OMH officials, this number may include the same visits that could have been billed to more than one insurance carrier. Using computer assisted audit techniques, we analyzed the database to determine the length of time between the date of the visit to the date of the initial billing. Our analysis showed that the time OMH took to submit a bill ranged from a low of 16 days to a high of 630 days. We also found that 107,059 bills (30.6 percent) were submitted for payment more than 90 days after the visit date; 5,205 bills were submitted more than one year after the visit date.

We found that the time to submit bills varied significantly from facility to facility. Nine facilities averaged over 90 days between the visit date and the date the bill was submitted for payment. Five of the 9 facilities were among the smaller outpatient programs, each of which had fewer than 10,000 patient visits per year. For example, Brooklyn Children's Psychiatric Center, with the highest average of 147 days, had the fewest outpatient visits (3,723). We also observed that Creedmoor, with 19,678 visits, had an average of 112 days, while South Beach, with the most visits (48,857), had an average of 75 days. (See Exhibit A.)

Bills are generated by OMH Central Office at predetermined times of the month. However, there are several factors under the control of the facilities which affect how long it takes to submit a bill for payment. These factors include the time it takes clinical personnel to submit service recording documents for data entry, the time it takes clerical staff to enter the data, and the accuracy and completeness of the data entered. Since the service recording documents provide the information needed to initiate the billing process, clinician delays in submitting these forms will result in delayed billing. Facilities also need sufficient clerical staff to enter service recording form data promptly and accurately in the DMHIS subsystem. Errors in data entry or missing information can result in transactions being returned to the facility for correction, further delaying the billing process.

OMH officials replied that in some instances, individual facilities may not be responsible for or have control over billing lags because OMH had

established lags for billing Medicare in an effort to more accurately bill in accordance with Medicare requirements. Regarding Brooklyn Children's Center, OMH officials indicated that this is a relatively new facility (which started billings in the Fall of 1998) and the billing delays were due in part to start-up issues requiring the training of staff in the billing process.

Recommendation

5. Take steps to ensure that all outpatient visits are billed on a timely basis. Investigate the large variances in billing delays at OMH facilities.

   (OMH officials replied that OMH Central Office will monitor and review the variances in billing delays among facilities (specifically those above the average number of days to bill, as shown in Exhibit A) and, as appropriate, make suggestions for improvement. Further, Creedmoor has made a concerted effort to ensure prompt data entry which has significantly reduced service recording lags.)

Analysis of COBS Database
Days Taken to Submit Bills for Outpatient Visits

Facility	Visits Made Between 4/1/98 - 3/31/99	Minimum Days to Submit Bill	Maximum Days to Submit Bill	Average Days to Submit Bill
Binghamton PC	5,691	21	622	74
Kingsboro PC	10,354	17	628	99
Buffalo PC	8,839	16	595	89
Creedmoor	19,678	16	625	112
Hudson River PC	9,120	21	594	81
Kings Park PC	1	57	57	57
Manhattan PC	4,628	18	630	116
Middletown PC	12,264	17	630	84
Pilgrim PC	27,435	16	629	137
NY Psych Institute	16,663	18	630	82
Rockland PC	24,927	16	630	85
St. Lawrence PC	22,549	19	629	69
Hutchings PC	26,645	19	625	98
Bronx PC	2,924	24	630	91
Capital District PC	9,660	21	630	122
Sagamore Child PC	5,241	21	538	110
Rockland Child PC	20,787	21	509	70
Queens Children's PC	20,418	19	625	51
Bronx Children's PC	7,490	20	434	64
Elmira PC	18,450	20	587	81
South Beach PC	48,857	19	629	75
Western NY Child PC	7,255	19	572	81
Mohawk Valley PC	16,281	19	625	67
Brooklyn Children's Ctr	3,723	22	630	147
ALL FACILITIES	349,880	16	630	87

EXHIBIT A

Major Contributors to This Report

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July 12, 2000

Kevin McClune
Audit Director
Management Audit
Office of the State Comptroller
A.E. Smith Office Building
Albany, NY 12236

Dear Mr. McClune:

The Office of Mental Health has reviewed the draft audit report entitled, Controls Over Outpatient Billings (99-S-31). Our comments to the findings and recommendations contained in the report are enclosed.

The Office of Mental Health appreciates the Office of the State Comptroller's continuing efforts to recommend improvements in our operations.

Many thanks for your continued help and cooperation.

Sincerely yours,

James L. Stone
Commissioner

Enclosure
cc: Diana Jones Ritter

Appendix B

OFFICE OF MENTAL HEALTH
RESPONSE TO OFFICE OF THE STATE COMPTROLLER
DRAFT REPORT 99-S-31
CONTROLS OVER OUTPATIENT BILLINGS

Overall Comments

OMH generally agrees with OSC's observations and recommendations to improve controls for outpatient billings; however, we are concerned that the draft report does not reflect the positive results of the OSC review concerning certain areas of the outpatient billing system.

During the preliminary audit work, OSC visited several facilities, including Hutchings PC in Syracuse. OSC's survey found that the billing practices at Hutchings PC were generally adequate. However, OSC then excluded Hutchings from their detailed audit, apparently focusing on those facilities where greater billing problems were anticipated. Further, OSC reviewed overall controls for the Comprehensive Outpatient Billing System in Central Office and, since no exceptions were noted, did not include this part of the review in the report. While OMH understands that OSC has a general policy of exception-based reporting, it seems reasonable that the report should be balanced with comments regarding work done by OSC in areas where the billing system was performing well, and we request that OSC include such comments in the final report.

OMH appreciates those changes OSC made to the report based on our response to the preliminary findings and observations, and we have modified our response accordingly.

Adequate documentation in the patient record continues to be a focus of OMH efforts. Toward this end, OMH is in the process of deploying an Electronic Medical Record, which automates the data in the medical record and adds electronic features such as triggers, alerts, scheduling and service reporting.

The Electronic Medical Record automates the clinical information processing system for all programs operated by OMH. OMH expects to implement EMR in phases with completion during 2001. The system is based on required OMH medical record forms and was developed by a team of OMH Center for Information Systems Management staff in conjunction with a multidisciplinary clinical team.

EMR captures all aspects of the mental and physical health of an individual while providing ready access to clinical knowledge bases and decision support tools. It is being developed to provide electronic linkages to other key OMH systems. It is consistent with NYS regulatory requirements, as well as JCAHO and HCFA standards. EMR also reflects the proposed Health Information Portability and Accountability Act standards for electronic patient information, as it relates to data confidentiality.

OMH approached the development of its Electronic Medical Record with several basic values in mind. It had to be a time saving device for clinicians while at the same time enhancing accountability. It also needed to provide a convenient and timely way to incorporate ever changing best practices and accreditation requirements. OMH has added to these considerations, privacy needs, linkages to other data systems, more rigorous billing requirements, and performance outcomes measurement.

The system will facilitate movement to a paperless record through the addition of a document imaging capability. This resource will allow all patient information to be stored electronically, providing for easy retrieval.

OMH expects that full implementation of the Electronic Medical Record will solve many of the issues noted during the OSC audit of outpatient billings.

OMH Comments to Specific OSC Findings and Observations

- **Information Missing in Patients' Medical Records**

  After OSC issued its preliminary findings, OMH conducted a survey of the six facilities reviewed by OSC during this audit. Our survey found that only one facility did not retain the service recording input forms nor document the supporting service information in the medical record according to policy, and/or guidelines. The final OSC report should be clear that only one of the six did not retain appropriate service data as required. OMH will take the corrective actions necessary to ensure that appropriate documentation to support any submitted claim is retained for the required period of time.

- **Analysis of the COBS Data Base -- Days Taken to Submit Bills for Outpatient Visits**

  In some instances, individual facilities may not be responsible for, or have control over, billing delays because OMH had established lags for billing Medicare in an effort to more accurately bill in accordance with Medicare requirements.

  Regarding Brooklyn Children's Center, this is a relatively new facility (which started billings in the Fall of 1998) and the billing delays were due in part to start-up issues requiring staff training.

OMH Comments to OSC Recommendations

OSC Recommendation No. 1

Take steps to ensure that clinicians accurately document in patients' medical records the outpatient

services they provide, including date of service and duration of service.

OSC Recommendation No. 2

Take steps to ensure that outpatient services are appropriately billed, including that clinicians complete service recording forms for all visits, and that clerical staff enter all visit data on the DMHIS service recording subsystem.

OSC Recommendation No. 3

Establish procedures to verify that data entry is performed accurately.

OMH Response to Recommendation Nos. 1 through 3

As stated in OMH's Overall Comments and expanded upon in this part of the response, the implementation of the Electronic Medical Record should correct many of the issues noted in the OSC report. For example, the many features of EMR provide OMH with functions which will greatly assist in ameliorating the conditions identified in the audit. EMR contains a reporting component which records services as part of progress note completion, as well as drop-down lists of eligible services. The link to progress note completion accomplishes multiple tasks including an automatic link to treatment plan goals, objectives, and methods to facilitate appropriate documentation of the services and user triggers to generate services which automatically link to billing.

As a result of these features, OMH believes EMR will assist in reducing errors related to insufficient documentation and services provided but not billed.

Although there is no method to assure that the progress note contains all information to support the bill, EMR provides linkages to goals, objectives, and methods in the treatment plan and the ability to copy data forward to the progress note, which will greatly enhance the potential for the progress note to contain appropriate content.

Prior to the full implementation of EMR, however, OMH facilities have already or will take corrective action to implement OSC recommendations. For example, Creedmoor PC has initiated daily clinical audits to ensure accuracy and completeness. Also, clinicians have been instructed to prepare progress notes and turnaround documents immediately after each billable visit. Where this is not possible, the date of the visit will be included in the note.

Rockland PC is planning training/instructional sessions this Summer to address billing and documentation concerns. Facility management expects to complete these sessions by Fall 2000. Service directors have begun random reviews of patient records to specifically check for progress notes and related service recordings. Further, the Utilization Review form was also amended to include a section to address the timeliness of progress notes, duration of service and outcomes.

In November 1999, Queens Children's PC developed a structured progress note to ensure that all billable services were accurately recorded on a weekly basis. To ensure complete compliance, the structured progress notes are reviewed as part of the Medical Records-Utilization Review process. Rockland Children's and Elmira PCs are also planning corrective actions to improve their outpatient billing processes.

Finally, South Beach PC has taken action to enhance its already effective procedures for documenting services provided and processing outpatient billings.

OSC Recommendation No. 4

Take steps to ensure that all facilities retain billing documents, such as the service recording forms, for the statutorily-required period.

OMH Response

OMH is in the process of reviewing its agency record retention policy for all documents in conjunction with the State Education Department, which is responsible for such State policies. OMH will take action to ensure that the appropriate documentation to support the services provided and submitted for reimbursement is being retained according to the retention period specified in regulations and/or policy. This action will encompass the audited facilities, along with those not included in this OSC review.

OSC Recommendation No. 5

Take steps to ensure that all outpatient visits are billed on a timely basis. Investigate the large variances in billing delays at OMH facilities.

OMH Response

OMH Central Office will monitor and review the variances in billing delays amongst facilities (specifically those above the average number of days to bill as shown in OSC Exhibit A) and, as appropriate, make suggestions for improvement.

Further, Creedmoor PC has made a concerted effort to ensure prompt data entry which has significantly reduced service recording lags. Error correction activities have also improved markedly.