



# **Office of Inspector General**

**Texas Health and Human Services Commission**

**Stuart W. Bowen, Jr., Inspector General**

## **Performance Audit Report**

**MHMR of Tarrant County**

**April 29, 2016**

**IG Report No. 15-26-R-03-17512494562-MH-01**

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## **EXECUTIVE SUMMARY**

The Health and Human Services Commission (HHSC), Inspector General (IG) has completed its performance audit on the Home and Community-based Services (HCS) program of MHMR of Tarrant County (MHMR). The audit focused on contract numbers 001007058 and 001019618 regarding funds paid through the Department of Aging and Disability Services (DADS).

### **Background**

MHMR is a Mental Health Center located in Fort Worth, Texas and administers several programs through the Health and Human Services Commission such as HCS. MHMR also serves as representative payee and local authority for several patients who live with their families, in their own home or in other community settings.

The HCS program is designed to provide services and support to people with mental health needs, intellectual and developmental disabilities (IDD) and other services, including nursing visits, supported employment (SE) and Activities of Daily Living (ADLs).

The audit of the provider covered the period from September 1, 2013 through August 31, 2014. Our review was limited to nursing services and service coordination within the HCS program. In addition, the Information Technology (IT) systems were reviewed to examine management's controls and data integrity. DADS paid MHMR \$4,565,369.07 for nursing services and service coordination in FY 2014.

### **Results**

We tested a sample of HCS claims with dates of service during our audit period. We identified the following major issues from our review:

- Billing for more services than delivered
- Non-billable activities submitted for payment
- Inaccurate documentation of services
- Missing progress notes
- Insufficient progress notes
- Lack of IT systems internal controls

IG recommends that MHMR return overpayments of \$10,908.66, ensure compliance with DADS program requirements, and follow Texas Administrative Code rules.

## Detailed Findings

### A. Billing Process

MHMR's billing process has three main phases:

Initially, nursing staff members are required to complete Progress Note and Service/Activity Log (SAL) the same day the service is performed. The nursing services are coded by the type of tasks/activities performed in the field. Currently, the nurse supervisor reviews the SAL before sending it to the clerk for verification and input.

The clerk verifies information including signatures, dates, and service codes to ensure the progress notes and SALs match. The clerk then inputs the units of billable services into MHMR's software called Community Mental Health Clinic (CMHC).

In the third phase, the billing coordinator exports the CMHC data to an Excel spreadsheet. The billing coordinator then reviews the claims data and performs several manual operations before it is entered into DADS billing system. The billing coordinator manually inputs the modified claims data into the DADS ID CARE system (C22) for payment.

#### A.1: Absence of Formalized Controls Through the Billing Process

The weaknesses and/or errors identified through the billing process are:

- There is no evidence to support the nurse supervisor's review or approval of the progress notes and SALs.
- There is no independent review to ensure that the units of billable services, entered into CMHC by the clerk, match those on the SAL. Once the clerk inputs information, including date, time, duration of service, and service code, there is no reconciliation to verify accuracy of data entered into the CMHC system.
- There is no independent review to ensure data entered into the C22 system by the billing coordinator matches the data in the CMHC system.

The absence of proper controls over the billing process could increase the risk of errors in units of billable services. Therefore, information in the C22 system may be inaccurate and could result in overpayments.

#### Criteria:

- *Section II.H. of the HCS Program Provider Agreement*

#### Recommendation:

MHMR should formalize and implement controls through the billing process to ensure completeness and accuracy of billing data.

MHMR should also implement controls to ensure that time entered in CMHC and C22 is accurate and properly reconciled.

**Management Response:**

*MHMR of Tarrant County ("MHMR") has implemented a formalized electronic billing review process that ensures the completeness and accuracy of billing data and has controls to ensure time is accurately entered. This review covered FY 14 and FY15, MHMR implemented an electronic systemic coding process for documentation of nursing services that will automatically generate the proper codes. This process also expedites the input of SALS into CMHC. MHMR is currently reviewing the effectiveness of incorporating a periodic review of nursing services documentation into its internal audit process or quality assurance review process. MHMR is in the process of implementing an electronic record which will minimize the potential of human error by limiting the amount of data entry required in multiple databases.*

**A.2: Billed Claims Not Found in CMHC**

We identified four claims that were billed in C22 but not recorded in CMHC.

Initially, we identified 37 claims that were billed but not in CMHC. A judgmental sample of 25 of the 37 claims was reviewed to determine why the claims were not recorded in CMHC. For 21 claims, we found that either the claims had the wrong service dates or the times were grouped. We were not able to substantiate four of the reviewed claims.

The presence of services billed in the C22 but not in CMHC increases the risk of inappropriate billing.

**Criteria:**

- *Section II.H. of the HCS Program Provider Agreement*

**Recommendation:**

MHMR management should review the billing process and implement proper controls to minimize incorrect billing.

**Management Response:**

*Because MHMR has not been provided copies of the 4 identified claims, it is unable to address the specific findings relating to these claims. However, CMHC is not a required system for billing services but instead is utilized to run internal reports in order to enter claims into C22 in a more efficient manner. MHMR will review the possibility of a reconciliation process and determine proper controls which will assist with identifying inconsistencies noted between CMHC and C22 so any inconsistencies can be addressed. MHMR is in the process of*

*implementing an electronic record which will minimize the potential of human error by limiting the amount of data entry required in multiple databases.*

**Audit Response:**

The corrective action stated in the management response appears to address the control weakness identified in the audit. To ensure that the specific control issues are addressed, an electronic file with the four claims identified above will be sent to MHMR via secured email.

**A.3: Overbilled Nurse Services**

We compared C22 and CMHC and identified 153 claim details out of 5,160 that have more time units billed in C22.

A judgmental sample of 25 claim details was reviewed and we were not able to substantiate five claim details. For most of the other 20 claim details, we found that multiple time units with different dates were grouped and billed as a total unit under one date.

The presence of unsupported time units in the CMHC increases the risk of inappropriate billing.

**Criteria:**

- *Section II.H. of the HCS Program Provider Agreement*

**Recommendation:**

MHMR should review the reconciliation of time units to determine the root cause and implement proper controls in the billing process to minimize overbilling.

**Management Response:**

*Because MHMR has not been provided copies of the claims identified as potentially problematic, it is unable to address the specific findings relating to these claims. However, CMHC captures actual time of events which are converted into the quarter increments of time required by the C22 system and this conversion may explain a difference in the amounts recorded between the two systems. MHMR will review the possibility of a reconciliation process and determine proper controls which will minimize the potential of human error by limiting the amount of data entry required in multiple databases.*

**Audit Response:**

To ensure that the specific control issues are addressed, an electronic file with the five claims identified above will be sent to MHMR via secured email.

#### **A.4: Billing for Higher Volume of Services Than Delivered**

**Nursing Services:** Out of 2,583 claim details, 107 claims were billed for higher hours than documented in the nursing progress notes. MHMR billed and was paid \$4,046.39 for these 107 claims.

We noted no independent review to ensure that service times entered into MHMR's CMHC system matched the service times in the progress notes and SALs.

MHMR was overpaid for services rendered.

#### **Criteria:**

- *DADS Home and Community-based Services (HCS) Handbook*
- *DADS Home and Community-based Service Program Billing Guidelines 3000*
- *DADS TCM Billing Guidelines*

#### **Recommendation:**

MHMR needs to augment billing procedures to ensure that billing codes, billable units or increments, and other information pertinent to the billing process entered into CMHC are supported and accurate. Additionally, procedures should be established to provide checks and balances to ensure correct data entry and to mitigate errors.

#### **Management Response:**

*Because MHMR has not been provided copies of the claims identified as potentially problematic, it is unable to address the specific findings relating to these claims. However, in FY14, MHMR provided and billed for 94,214 Service Coordination claims. One service coordination claim which was billed twice represents an isolated example of a human error and not a systemic problem.*

*Additionally, the discrepancy discussed relating to nursing services may be as a result of the allowed accumulation of service times. According to the HCS Billing Guidelines, "A program provider may accumulate service times, as described in Section 3610, 15-Minute Unit of Service, for {nursing} provided to one individual during a single calendar month. The service times of more than {nurse} may be accumulated on the last day of the month."*

*In FY15, MHMR implemented processes to ensure claims entered into CMHC are supported and accurate. Management has implemented an electronic systemic coding process for documentation of nursing and service coordination services that will automatically generate the proper service activity log codes. In addition, for Service Coordination services, checks and balances have been implemented in the form of internal Medicaid Audit reviews, data reporting and reconciliation, quality assurance reviews and additional staff training. MHMR is in the process of implementing an electronic record which will minimize the potential of human error by limiting the amount of data entry required in multiple databases.*

## **Audit Response:**

MHMR was provided with the additional requested missing claims information on December 11, 2015. This information included the client name, sample number, date of service, unit of service billed and the service type. Even though this information was provided at the exit in July, MHMR was given an additional fourteen (14) business days to respond to the draft report.

Auditors agree that one error in the Service Coordination sample tested does not represent a systematic problem in this area. For this reason, the finding for that claim detail was overturned.

While a program provider is allowed to accumulate services times, we found that the same dates of service included in the accumulation were also billed as separate, stand-alone claims for the same date. Based on further review, two claims were removed and the questioned cost reduced.

### **A.5: Non-Billable Activities Submitted for Payment**

**Nursing Services:** Our review of the medical records revealed that MHMR was paid for non-billable activities that either did not require a nurse or for activities that were non-billable according to DADS HCS Billing Guidelines such as:

- Performing an activity for which there is no medical need;
- Performing or supervising an activity that does not constitute the practice of a licensed nurse;
- Instructing staff on general topics unrelated to specific clients;
- Preparing a medication or treatment for administration and not interacting face to face with the client;
- Storing, counting, reordering, refilling or delivering medication; and
- Reviewing a written service log - Interacting with a service provider of any nursing service component outside of a service planning meeting or individual plan of care development.

Out of 2,583 claim details, 167 claims were billed for non-billable services. MHMR billed and was paid \$4,017.40 for these 167 claims. Examples of non-billable services that were submitted for payment include:

- Nurse to nurse communication;
- Writing out progress notes;
- Chart review;
- Prepping medications;
- Review of logs including medication, bowel movement and vital signs;
- Non-billable form preparation (e.g. non-emergent form);
- Waiting for fire department in unsafe conditions with no evidence of follow up training for the client and/or care providers; and
- Observation of Licensed Vocational Nurse (LVN) while not providing direct care to the client.

**Service Coordination:** Additionally, for one Service Coordination claim detail, MHMR billed and was paid \$30.00 for a non-billable activity. The Service Coordinator billed for leaving a Support Manager a voicemail.

No evidence of a supervisor checking off the progress notes and no evidence of appropriate training to staff about non-billable activities was found.

Billing for non-billable activities results in the provider's non-compliance with the contract, applicable laws, rules, and regulations of the program.

**Criteria:**

- *DADS Home and Community-based Services (HCS) Handbook*
- *DADS Home and Community-based Service Program Billing Guidelines 3000*
- *DADS Home and Community-based Service Program Billing Guidelines 4000*
- *DADS TCM Billing Guidelines*

**Recommendation:**

MHMR nursing and service coordination supervisory staff should review progress notes to ensure that only billable activities are submitted for reimbursement in accordance with DADS HCS Billing Guidelines. A process of ongoing employee education and training on these billing guidelines should be implemented.

**Management Response:**

*The following were noted as non-billable activities submitted for payment during the July 2015 exit conference, but, according to HCS Billing Guidelines, were actually billable services: "at the time an individual receives medication from a pharmacy, ensuring the accuracy of: the type and amount of medication; the dosage instructions; and checking medications at the time they are received from the pharmacy for matching labels with the doctor's order and medication administration record sheet (MARS) for correct type and amount of medication, or additional times when there are documented medication errors or labs that show the individual's therapeutic levels are abnormal; instructing a service provider, except a service provider of registered nursing or specialized register nursing, on a topic that is specific to an individual such as choking risk for an individual who has cerebral palsy; supervising a licensed vocational nurse regarding an individual's nursing services or health status." However, although MHMR correctly billed many services identified as unbillable, MHMR will provide additional training to ensure appropriately detailed documentation is included in progress notes. The nurse supervisor completed training on 6-11-15 and 7-9-15 to cover the HCS Billing Guidelines and proper documentation to support the billable service.*

*Further, MHMR is currently reviewing the effectiveness of incorporating a periodic review of nursing services documentation into its internal audit process or quality assurance review process. MHMR has enhanced processes to ensure claims entered into CMHC are supported and accurate. Management has implemented an electronic systemic coding process for documentation of nursing and service coordination services that will automatically generate the*

*proper service activity log codes. In addition, initial and on-going training has been implemented with a focus on billable activities and clear documentation. MHMR is in the process of implementing an electronic record which will minimize the potential of human error by limiting the amount of data entry required in multiple databases.*

**Audit Response:**

MHMR was provided with the additional requested missing claims information on December 11, 2015. This information included the client name, sample number, date of service, unit of service billed and the service type. Even though this information was provided at the exit in July, MHMR was given an additional fourteen (14) business days to respond to the draft report. The non-billable activities that auditors took exception to were provided in the draft report.

Sections 4430 and 4471.3 of the HCS Billing guidelines lists activities that are considered non-billable. Auditors did not take exceptions for activities that were billable according to HCS Billing Guidelines. Also, a claim detail that had a secondary exception of non-billable activities has been added to this finding. Therefore, the claim details for nursing services were adjusted to 167 and the questioned cost to \$4,017.40.

**A.6: Conflicting or Inaccurate Documentation of Services**

**Nursing Services:** Out of 2,583 claim details, 12 claims were not verifiable due to conflicting or inaccurate supporting documentation. MHMR billed and was paid \$222.10 for these 12 claims. Examples of this conflict or inaccurate supporting documentation include:

- Progress note with conflicting times and/or dates throughout the document;
- One progress note contains information on two different clients;
- Progress notes signed by both a Registered Nurse (RN) and an LVN, thus unable to determine if the correct rate was billed;
- Supervisory time on RN's progress note conflicts with the time documented by the staff LVN; and,
- Duplicate nursing notes with same narrative for two consecutive days.

In some cases, the documentation did not contain clear dates, identity of client, accurate times and a signature of the nurse providing the service. Additionally, the progress notes of the supervisor conflict with the progress notes of the staff.

**Service Coordination:** Out of 1,039 claim details, 16 claims were not verifiable due to conflicting or inaccurate supporting documentation. MHMR billed and was paid \$731.20 for these 16 claims. Examples of this conflict or inaccurate supporting documentation include:

- Progress note signed by staff other than staff that provided care;
- Progress note signed over seven months after the service was provided;
- Progress note with location type conflicting with contact type; and
- Progress notes with illegible signatures.

We noted no evidence of a supervisor checking off the progress note to ensure Nursing and Service Coordination progress notes contained accurate and matching information before being billed.

It is not possible to determine if care was provided for these claim details due to conflicting components and inaccuracy of the documentation. Review to ensure clarity and accuracy of progress notes is essential to prevent documentation of inaccurate information.

**Criteria:**

- *DADS Home and Community-based Services (HCS) Handbook*
- *DADS Home and Community-based Service Program Billing Guidelines 3000*
- *DADS TCM Billing Guidelines*

**Recommendation:**

MHMR should require a supervisory review that includes checking for timeliness and accuracy of all elements on the progress notes, and ensure that progress notes are sufficiently documented per DADS guidelines.

**Management Response:**

*MHMR will continue to provide additional training to ensure appropriately detailed documentation is included in progress notes. The Nurse Supervisor completed training on 6-11-15 and 7-9-15 to cover the HCS Billing Guidelines and proper documentation to support the billable service. Further, MHMR is currently reviewing the effectiveness of incorporating a periodic review of nursing services documentation into its internal audit process or quality assurance review process.*

*MHMR has implemented processes to ensure claims entered into CMHC are supported and accurate. Management has implemented an electronic systemic coding process for documentation of nursing and service coordination services that will automatically generate the proper service activity log codes. In addition, initial and on-going training has been implemented with focus on billable activities and clear documentation.*

*MHMR is in the process of implementing an electronic record which will minimize the potential of human error by limiting the amount of data entry required in multiple databases.*

**Audit Response:**

A review of the information submitted did not have both the specified date and required dated signature to clear the claim in question. In addition, a claim detail with a secondary exception of inaccurate documentation has been added to this finding. As a result, the number of claims with exceptions increased from 15 to 16 claim details.

## **A.7: Missing Progress Notes**

**Nursing Services:** Out of 2,583 claim details, 80 claims did not have supporting nursing progress notes to validate claims. MHMR billed and was paid \$1,365.79 for these 80 claims.

**Service Coordination:** Additionally, MHMR was unable to provide progress notes to validate 8 of 1,039 Service Coordination claim details. The provider billed and was paid \$365.60 for these 8 claim details.

MHMR was paid for claims for which no supporting documentation is available. The provider received payment for services which progress notes could not be reasonably validated. The provider either lost some of the records and progress notes, or the records and progress notes were not recorded and/or filed correctly.

### **Criteria:**

- *DADS Home and Community-based Services (HCS) Handbook*
- *DADS Home and Community-based Service Program Billing Guidelines 3000*
- *DADS Home and Community-based Service Program Billing Guidelines 4000*
- *DADS TCM Billing Guidelines*

### **Recommendation:**

MHMR should ensure that the records are retained to ensure proper support for billed services. Controls should be implemented to ensure only services with progress notes are billed and the provider should implement controls to ensure record retention as required.

### **Management Response:**

*Many of the Nursing Notes and Service Coordination Notes noted as missing were in fact never missing, and were provided to the auditors during the review period. However, MHMR is again producing these documents and they are attached to this report.*

*MHMR is in the process of developing new chartroom procedures to ensure effective and efficient filing of all documents. Additionally, MHMR is providing training for all chartroom staff and this training will be provided to the chartroom staff by March 1, 2016.*

*MHMR has implemented processes to ensure claims entered into CMHC are supported and accurate. Management has implemented an electronic systemic coding process for documentation of nursing and service coordination services that will automatically retain the documentation. MHMR will review the possibility of a reconciliation process and determine proper controls which will assist with identifying inconsistencies noted between CHMC and C22 so any inconsistencies can be addressed.*

*MHMR is in the process of implementing an electronic record which will retain the documentation and ensure an electronic signature.*

## **Audit Response:**

After careful review, it has been determined that documents were provided that cleared the findings for three claim details. In other cases, documents submitted were not sufficient to cover instances that involved multiple claim details for one date of service that may include different service types and units for one date of service. For example, a client was billed one unit for registered nursing services (NUR) three times on the same date. Two NUR notes were provided for ten minutes each. This would only support two of the three claim details; evidence to support the third claim detail is still needed.

Information regarding specific claims relating to this issue was provided both at the Exit conference as well as in the email dated December 11, 2015.

### **A.8: Insufficient Progress Notes to Validate Claims Due to Missing Elements**

**Nursing Services:** Out of 2,583 claim details, four claims were missing a required documentation element in the nursing progress notes. MHMR billed and was paid \$130.18 for these four claims.

- Two claim details were missing any individualized narrative to indicate what was provided to the client;
- One claim detail was missing a service date on the progress note. The facility provided a nursing comprehensive assessment update to support this claim. However, the claim is unable to be validated as the assessment did not have a beginning and end time to match the progress note; and
- For one claim detail, the typed progress note was not signed by the nurse. The absence of a signature raises a question regarding the provision of services.

No formal evidence of a nursing supervisor checking off the progress note to ensure nursing progress notes contained required elements before being billed.

As a result of the missing elements, we are unable to validate delivery of service, rendering the services non-billable due to insufficient documentation.

### **Criteria:**

- *DADS Home and Community-based Service Program Billing Guidelines 3000*

### **Recommendation:**

MHMR should review DADS HCS Guidelines for recording progress notes and establish procedures for recording progress notes. The procedures should include nursing supervisor reviewing the nursing progress notes for required elements before being billed.

## **Management Response:**

*Although MHMR does not believe 4 claims out of 2,583 claims statistically significant, it implemented additional training on the DADS HCS Billing Guidelines and all required elements to bill for service provision was provided to the nurses on 6-11-15 and 7-9-15.*

*MHMR has implemented an electronic systemic coding process for documentation of nursing services that will automatically retain the documentation. MHMR is currently reviewing the effectiveness of incorporating a periodic review of nursing services documentation into its internal audit process or its quality assurance review process. MHMR will review the possibility of a reconciliation process and determine proper controls which will assist with identifying inconsistencies can be addressed.*

*MHMR is in the process of implementing an electronic record which will retain the documentation and ensure an electronic signature.*

## **Audit Response:**

The provider did not submit additional information to clear this finding. The finding remains.

## **B. Internal Control Findings – IT Governance, Infrastructure and Operational Support**

The following internal control findings were identified as part of an integrated approach to assess and evaluate the Information Technology (IT) governance infrastructure to support the management and administrative operations. This assessment and evaluation is based on standards and guidance promulgated in one or more of the following reference sources:

- Control Objectives for Information and Related Technology (COBIT), promulgated by the *Information Systems Audit and Control Association*;
- Committee on Sponsoring Organizations of the Treadway Commission (COSO), promulgated by the *Institute of Internal Auditors*; and
- Generally Accepted Government Auditing Standards (GAGAS), promulgated by the *U.S. Government Accountability Office*.

Only high risk findings are included in this report; however specific details regarding application software, operating systems, user account privileges, and other sensitive information are not included in this report to ensure the confidentiality of proprietary applications used for operations. These detailed findings, including low and medium risk findings, have been provided to the management of MHMR under a separate limited-use report.

### **B.1: IT Risk Evaluation Process Not in Place**

There is not a formal IT risks evaluation process in place. The IT risk evaluation process is necessary to ensure the assessment and protection of assets. The absence of an IT risk evaluation process exposes the information system to security threats and potential compromise.

**Criteria:**

- *COSO and COBIT*

**Recommendation:**

Management should implement a formal risk evaluation process to identify and manage IT related risks.

**Management Response:**

*Management has implemented an IT Risk Assessment Process to identify and manage IT related risks.*

**B.2: Absence of Segregation of Duties Within the Accounting System**

There is no segregation of duties among the different layers of the accounting system. At this time, eight staff members have knowledge of the administrator password of the application, the database and the operating system.

The absence of segregation of duties among the administrators of the different layers (application, database and operating system) of the system could result in unauthorized activities.

**Criteria:**

- *COSO and COBIT*

**Recommendation:**

MHMR management should ensure a proper segregation of duties among the administrators of the different layers (application, database, and operating system) of the accounting system.

**Management Response:**

*Adjustments have been made and implemented (June 2015) regarding the segregation of duties among the system layers.*

**B.3: IT Staff with Permanent Administrator Access to the Accounting Application**

We identified ten IT staff with a permanent administrative access privilege to the accounting application. Specific listing of these users has been provided to management in a separate report.

Granting a permanent administrator access privilege to the IT staff increases the risk of unauthorized activities in the accounting application. This could affect the integrity of the financial reporting process.

**Criteria:**

- *COSO and COBIT*

**Recommendation:**

Management should disable the IT staff's administrative access to the accounting application. If access to the accounting application is required to perform a task, the standard user management procedure should be followed to request the required access. That access should be granted just for the time needed to perform a specific task, and should expire after task completion.

**Management Response:**

*IT staff access to the accounting system has been revised accordingly. The standard user management procedure is followed for IT staff access, which grants, and removes access as required. The IT staff has received additional training (June 2015) on this procedure.*

**B.4: Utilization of Generic Accounts with a Shared Password**

We identified the presence of nine generic accounts with shared passwords in the accounting application.

The use of generic accounts with shared password increase the risk of unauthorized activities.

**Criteria:**

- *COSO and COBIT*

**Recommendation:**

Management should attribute a nominal user account to each user and prohibit the utilization of generic accounts.

For the generic accounts required by the systems, management should limit the number of users with the password access and monitor the activities of these generic accounts by performing a periodic audit trail or log review.

**Management Response:**

*Utilization of the generic accounts has been limited to service accounts, as required. The password access has been limited to authorized users whose job functions require servicing or monitoring these generic accounts. A procedure for monitoring the activities of the generic accounts has been implemented.*

## **B.5: Audit Trails Not Recorded and Monitored for the Database**

Management was unable to provide the evidence that audit trails are recorded and monitored for the activities performed in the accounting application database by the administrator. Without recording and reviewing audit trails for the database administrator accounts, it will be difficult to detect unauthorized activities in the database in a timely manner and then to guarantee the database integrity.

### **Criteria:**

- *COSO and COBIT*

### **Recommendation:**

IT management should activate the audit trails to track activities performed in the database by users with sensitive privileges, such as database administrators (privileged user accounts). Management should ensure that these audit trails remain activated, are secured and are periodically reviewed by an independent staff member to track unauthorized activities.

### **Management Response:**

*Audit trails are available in the application and these are active, secured and unalterable. Independent periodic review procedures of the audit logs will be defined by February 1, 2016.*

*MHMR has internal policies & procedures to manage privileged users' access to the database. Active audit trails are available for general system users; however, audit trails currently do not exist for privileged users' access of the database. Management is determining the most efficient and economical process for the MHMR to implement the recommended audit trail functionality.*

## **B.6: Noncompliance with the Change Management Policy**

For a sample of five changes, we did not obtain the different deliverables required by the change management policy. Based on our review of the process in place, we understood that the Data Management Team (DMT) identified in the policy no longer exists.

The non-compliance with the Change Management policy increases the risk of inaccuracy of data processed by the accounting system due to an improper change.

### **Criteria:**

- *COSO and COBIT*

### **Recommendation:**

Management should comply with the process as described in the Change Management policy, or update the policy to reflect the current operations of the company.

## **Management Response:**

*The Change Management Policy has been updated to reflect the current operations of the company. The Policy is pending final approval (March 1, 2016).*

## **B.7: Incomplete Disaster Recovery Plan (DRP)**

There is no clear recovery strategy defined in the DRP. The current plan does not contain the following key elements:

- List of critical IT assets/systems to recover;
- The recovery time objective(s); and
- The recovery procedure for each IT asset/system.

Without a clear recovery strategy, there is an increased risk that critical systems may not be recovered after a disaster, or delays in recovery could seriously impact business operations.

## **Criteria:**

- *COSO and COBIT*

## **Recommendation:**

Management should develop and implement a DRP that is aligned with the Business Continuity Plan (BCP). The plan should clearly reflect the essential elements of an effective DRP.

## **Management Response:**

*Business Continuity Planning (BCP) is an ongoing activity. A Disaster Recovery Plan (DRP) is being developed and should be completed in CY2016 and will be aligned for implementation (April 1, 2016.)*

## **C- Personnel Findings – Background Checks and Verification – Driving Record and Licensing Renewals for Hired Staff.**

### **C.1: No Evidence of Nursing License Verification**

Our review of four personnel records for nurses revealed the absence of a renewal verification for one Registered Nurse's license prior to the expiration date to ensure the personnel remained in good standing with licensing requirements. There was no evidence to support that management and/or staff conducted verification procedures for nursing staff subsequent to the license expiration. However, responsible management stated that the license was verified by a new staff member who "didn't understand the importance of the paper trail." License renewal verifications are critical to prevent staff from performing medical care without a license.

**Criteria:**

- *TAC Title 40, Part 1, Chapter 9, Subchapter D, Rule §9.177 Certification Principles: Staff Member and Service Provider Requirements.*

**Recommendation:**

MHMR should ensure that staff is trained correctly on performing nursing license verification.

**Management Response:**

*MHMR was not provided information on the identity of the professional whose license might have lapsed and, therefore, cannot establish this or resolve accordingly.*

*The OIG auditor did not interview any of the staff of the Credentialing Department in reference to the verification process and procedures for nursing license. The Credentialing Department is solely responsible for license verifications, alerts of expiration, and compliance. The staff is experienced and trained on performing license verification as demonstrated by the fact that the Manager of Credentialing has been employed with MHMR for 25 years and her two direct reports have a combined 14 years of service.*

**Audit Response:**

Although we did not interview the employees of the Credentialing Department to determine verification process, the Operating Procedure NM-033- Credentialing/Re-Credentialing of Professionals was provided to us during the audit. This document includes the procedures for verification of licenses.

The name of the staff will be provided to MHMR accordingly.

# Appendices

**OBJECTIVE, SCOPE, AND METHODOLOGY****Objective**

The audit objectives were to determine whether the services billed by MHMR of Tarrant County (MHMR) to the State's Home and Community-based Services (HCS) program were allowable and the provider followed pertinent rules and regulations.

Applicable criteria are contained in the Texas Medicaid Provider Procedures Manual, Texas Department of Aging & Disability Services (DADS) HCS Handbook, DADS HCS Billing Guidelines, the Texas Administrative Code (TAC), Generally Accepted Accounting Principles, and the Texas Health and Human Services Commission policies and procedures.

**Scope**

The audit of MHMR covered the period from September 1, 2013 through August 31, 2014. The audit included an examination of the services billed for Medicaid recipients, as authorized by the contracts. We also reviewed the related financial records such as payroll register and general ledger of the provider. The Information Technology systems were also reviewed to examine management's controls, determine if data integrity is maintained and that the system operates effectively.

**Methodology**

The methodology employed during this performance audit included objectively reviewing and analyzing various forms of documentation, conducting interviews and observations, and performing other tests necessary to achieve the objectives of the audit. We conducted an on-site review of medical records, billing, and conducted home visits with intellectual and developmental disability (IDD) clients who receive services under the DADS HCS program. We also reviewed client medical records and assessed the quality of care administered to clients in the DADS HCS program.

During the engagement, we interviewed operational and administrative personnel and performed tests of accounting records, as well as reviewed the following documents:

- Independent audit reports
- Contracts
- Policies and Procedures
- Organizational chart
- Board minutes
- Data extractions from DADS' ID CARE system
- Client records
- Licenses and certifications
- Notes from interviews

## APPENDIX A (Cont'd)

We used judgmental sampling to determine the extent to which MHMR correctly billed for Medicaid claims. We conducted our sampling methodology in accordance with guidance issued by the American Institute of Certified Public Accountants and Statements on Auditing Standards (SAS) Number 39.

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and recommendations. Based on our audit objectives, we believe that the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objective.

### **Criteria Used**

HCS Program Provider Agreement  
DADS Billing Guidelines for Targeted Case Management (TCM)  
DADS Home and Community-based Services (HCS) Handbook  
DADS Home and Community-based Service Program Billing Guidelines  
TAC Title 40, Part 1, Chapter 9, Subchapter D, Rule §9.177 Certification Principles: Staff Member and Service Provider Requirements  
TAC Title 25, Part 1, Chapter 414, Subchapter K, Rule §414.504 Pre-employment and Pre-assignment Clearance  
COSO  
COBIT

### **Team Members**

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## SAMPLING PROCEDURES AND RESULTS

### Sampling Frame

The sampling frame (population) was the provider's claims paid by Texas Medicaid & Healthcare Partnership (TMHP) that had a "date of service" within the audit period September 1, 2013 through August 31, 2014.

### Sample Unit

The sampling unit is a paid claim. A paid claim may include one or more claim details. Paid claims in this sample are for Medicaid services rendered to a Medicaid recipient by a contracted provider for which, a) TMHP paid MHMR, and b) have a "date of service" within the audit period September 1, 2013, through August 31, 2014.

### Sampling Procedures

We conducted our sampling methodology in accordance with guidance issued by the American Institute of Certified Public Accountants and Statements on Auditing Standards (SAS) Number 39. A judgmental sample of items from the population was tested to determine the extent to which MHMR billed correctly for Medicaid claims. Questioned costs were calculated on a dollar for dollar basis.

### Testing Results

The tables below summarize the results of our claims testing:

Nursing Services Claims Testing				
Exception taken	Number of occurrences	Total amount	Claim error rate	Dollar error rate
Billing for higher volume of services than delivered	107	\$4,046.39	4.14%	10.03%
Non-billable activities billed as Nursing Services	167	\$4,017.40	6.47%	9.95%
Conflicting or inaccurate documentation of services	12	\$222.10	0.46%	0.55%
Missing progress notes	80	\$1,365.79	3.10%	3.38%
Documentation element missing	4	\$130.18	0.15%	0.32%
<b>Sub total</b>	<b>370</b>	<b>\$9,781.86</b>	<b>14.32%</b>	<b>24.24%</b>
<b>Total amount and claim detail tested</b>	<b>2,583</b>	<b>\$40,356.10</b>		

**APPENDIX B (Cont'd)**

<b>Service Coordination Claims Testing</b>				
<b>Exception taken</b>	<b>Number of occurrences</b>	<b>Total amount</b>	<b>Claim error rate</b>	<b>Dollar error rate</b>
<b>Non-billable activities billed as Nursing Services</b>	1	\$30.00	0.10%	0.06%
<b>Conflicting or inaccurate documentation of services</b>	16	\$731.20	1.54%	1.45%
<b>Missing progress notes</b>	8	\$365.60	0.77%	0.72%
<b>Sub total</b>	<b>25</b>	<b>\$1,126.80</b>	<b>2.41%</b>	<b>2.23%</b>
<b>Total amount and claim detail tested</b>	<b>1,039</b>	<b>\$50,449.60</b>		

**REPORT DISTRIBUTION**

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