

Committee Report, Vol. 11, No. 1
**The Lincoln Regional Center's
Billing Process**

December 2004

**Performance
Audit Section**

*Legislative Research Division
Nebraska Legislature*

Legislative Performance Auditing

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Key Findings & Recommendations

Legislative Performance Audit Section Report *The Lincoln Regional Center's Billing Process*

Because the state is primarily responsible for funding the regional centers, and because the state has been experiencing record-low revenues, the Legislative Performance Audit Committee (Committee) asked the Performance Audit Section (Section) to determine whether the Lincoln Regional Center (LRC) is maximizing its resources through the use of efficient billing practices and vigorous pursuit of reimbursements due the state from patients and third parties (private insurers, Medicare, and Medicaid). The audit team issued its draft report in May 2004. Following a public hearing on 10 September 2004, the Committee adopted findings and recommendations

Findings

Based on the Section's research, it appears that there is at least a possibility that significant reimbursement amounts due the state as a result of the provision of mental health services are going uncollected because the system used at LRC to bill individuals and third-party payers (private insurance companies, Medicare, and Medicaid) is not functioning effectively. The Section could arrive at no conclusive determination as to how much, if any, money owed to the state is being foregone because the documentation that would allow them to make such a determination is insufficiently gathered and maintained.

Examples of inadequate documentation:

- LRC's computer system, AIMS, could not report the total dollar value or the total number of reimbursement claims submitted and denied, either in the aggregate or on a per-person basis. (It could only report the total dollar value of third-party payments received.) The Section does not believe LRC's new computer system, Avatar, will do so either;
- Nothing is being done to fill in the gaps left by the inadequate computer systems. A spreadsheet could be used to keep claim, payment, and denial totals, but HHSS Finance and Support Agency (Finance Section) managers have not required their staff to collect and maintain this information in a usable form; and
- The HHSS Services Agency's Health Information Management Division (HIM)—which is responsible for collecting patients' medical information and providing it to third-party payers—does not maintain adequate documentation of its correspondence with third-party payers or of physician decisions regarding the submission of denied claims. As a result, it is impossible to discern whether HIM is sending the information requested by third-party payers that might result in a claim being reimbursed. In addition, the lack of documentation regarding physicians' decisions to pursue (or not pursue) denied claims made it very difficult for the Section to assess LRC's efforts in collecting payments for resubmitted claims.

There also appears to be a significant breakdown of communications between the two offices—HIM and the Finance Section—that have responsibility for different aspects of the billing process. Because collecting reimbursements of most denied claims requires the cooperation of both offices, it is imperative they communicate effectively. During the audit, the Section found very little evidence that suggested the two offices communicated as needed. As a result of this communication breakdown, the two offices are hampered in their ability to carry out their collection duties.

Because of the way the billing process and HHSS are organized, there is effectively no single individual who oversees the entire process and can require the Finance Section and HIM to cooperate. This is a significant problem that needs to be remedied.

Recommendations

In order to resolve issues that preclude the billing system from functioning effectively, the Committee recommends that:

- Finance Section management recognize the importance of keeping data that will enable its staff to determine whether it is successful in its efforts to collect money owed to the state. If LRC's new computer system cannot produce critical reports to that end, Finance Section management should instruct staff to use something as simple as a spreadsheet to track claims, payments, and denials; and
- HIM maintain documentation of its correspondence with third-party payers: private insurance companies, Medicare, and Medicaid. In addition, HIM needs to better document physician decisions regarding the submission of denied claims.
- A structural reorganization designed to give someone authority to oversee the LRC billing process should be considered. Billing is currently the responsibility of two separate offices—the Finance Section and HIM—that are under the jurisdiction of two separate and co-equal HSSS agencies—the Finance and Support Agency and the Health and Human Services Agency, respectively. We believe that something needs to be done—perhaps the creation of a mid-level management position—to ensure that each office does its part and communicates with the other office. Although we are not anxious to add a bureaucratic layer, an effective solution to this problem needs to be found.

LRC Hearing

The Committee takes exception to the way in which HHSS Finance and Support Agency management responded to the audit report, in terms of both the statutorily required written agency response and the testimony presented on behalf of the agency at a public hearing in September. The Committee believes that the agency management was dismissive of and uncooperative with the performance audit process. The Committee's observations can be found at the start of its findings and recommendations.

Part II

Performance Audit Section Report

Performance Audit Section Report
**The Lincoln Regional Center's
Billing Process**

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INTRODUCTION

For decades, the state of Nebraska has provided mental health services to people who cannot afford private care. The state delivers these services through three psychiatric hospitals known as regional centers.

Nebraska's Health and Human Services System (HHSS) administers the regional centers, which are located in Hastings, Lincoln, and Norfolk. Each of these facilities provides in- and out-patient services. In addition, an HHSS office on the Lincoln Regional Center campus oversees the billing processes for all three centers.¹

Most of the regional centers' residents lack the financial resources to pay for their own care, and either lack insurance coverage for mental health services or quickly exhaust that coverage. Consequently, the vast majority of the regional centers' funding comes from the state's General Fund. When possible, however, the regional centers pursue payments from residents or any third party with a legal obligation to pay for the residents' services.

Because the state is primarily responsible for funding the regional centers, and because the state has been experiencing record-low revenues, the Legislative Performance Audit Committee (committee) asked the Performance Audit Section (section) to determine whether the regional centers are maximizing their resources through efficient billing practices and vigorous pursuit of third-party reimbursements. To address these concerns, the committee requested an in-depth review of the billing processes of one of the three regional centers. It asked the section to conduct such a review at the Lincoln Regional Center (LRC) because it houses the office that oversees billing for all three regional centers.

In Section I of this report, we provide an overview of LRC's administration, programs, and funding. In Section II, we describe LRC's billing process and areas of concern we noted that stem from this process. In Section III, we review and analyze data we collected relating to third-party reimbursements. In Section IV, we review billing-process management practices and discuss our related concerns. In Section V, we summarize our findings and present our recommendations.

¹ This office also oversees billing for the Beatrice State Developmental Center. The Beatrice facility provides residential services for Nebraskans with mental retardation and related conditions.

We appreciate the cooperation and assistance provided by staff members in the LRC's Financial Responsibility Section and Health Information Management Division.

SECTION I: The Lincoln Regional Center

In this section, we provide an overview of the Lincoln Regional Center's (LRC's) administration, programs, and funding.

Administration

The administration of LRC is divided between two Health and Human Services System (HHSS) agencies. The Health and Human Services Agency provides services to LRC's residents and maintains documentation of each resident's medical condition and treatment. The Finance and Support Agency administers the billing process and maintains documentation of each resident's financial resources.

Programs

LRC primarily provides inpatient psychiatric services to adults and adolescents.¹ In FY2002-03, LRC served 592 residential patients in four programs: Adolescent and Family Services, Forensic Mental Health Services, Short Term Care, and Community Transition.

The average length of stay for an LRC resident is 224 days. However, the average length of stay ranges from 75 days for the residents in the Short Term Care Program to 954 days for convicted sex offenders in the Forensic Mental Health Services Program. Depending on the program, the per-patient cost ranges from \$281 to \$862 per day.

An individual may enter LRC voluntarily, through self-admission, or involuntarily, through a commitment order by a court or mental health board.² The means by which a resident is admitted is important because, in some cases, it determines the entity that is required to pay for the resident's services. We discuss this issue further in Section II.

Funding

As mentioned in the Introduction, the vast majority of LRC's funding comes from the state's General Fund. In FY2002-03, LRC received about \$26.6 million in appropriations, of which about \$22.6 million, or 85 percent, came from the General Fund. The remaining

¹ In FY2002-03, LRC provided out-patient services to less than five percent of the patients it served. However, the proportion of out-patient services is much higher at the other two regional centers.

² Mental health boards have the authority to commit mentally ill individuals whom they believe to be a danger to themselves or others. These boards are appointed by the presiding district court judge.

\$4.0 million came from a variety of sources, primarily third-parties such as private insurance companies, Medicare and Medicaid.³

Table 1, below, demonstrates the breakdown of funding sources utilized by LRC.

Table 1. FY2002-03 LRC Appropriations		
<i>Source</i>	<i>Amount</i>	<i>Percentage</i>
General Fund	\$22,650,195	85
Third-parties	2,092,849	8
Residents	253,119	1
Counties ⁴	1,209,282	4
Other	431,173	2
Total	\$26,636,618	100

In the following section, we describe LRC’s billing process and identify areas of concern that stem from it.

³ We note that, in FY2002-03, LRC spent about \$27.2 million, or about \$593,000 more than its appropriation. According to the HHSS Finance and Support Agency, the difference was covered by carryover funds from the previous fiscal year.

⁴ By statute, LRC collects payments from the home counties of residents admitted to LRC. (A patient’s home county can be either the patient’s county of residence or the county that is financially responsible for the patient.) In addition, if a court orders a resident committed to LRC to undergo certain types of psychiatric evaluations, the county requesting the evaluation is liable for its cost.

SECTION II: The Lincoln Regional Center's Billing Process

As described in Section I, LRC receives funding from several sources, including the state General Fund, LRC residents, and third parties such as counties, private insurance, Medicare, and Medicaid. In the case of the non-General Fund revenue, LRC must bill liable residents or third parties to obtain payment. In this section, pursuant to the scope statement for this audit, we describe the billing process LRC uses in collecting these payments and report our concerns about that process.

Finding: LRC has no written policies to guide the billing process.

Before describing the billing process, we note that LRC has no comprehensive written policies to guide it.¹ Consequently, the following description is based solely on our interviews with staff members and our observations of the documentation in the case files we reviewed for the analysis we present in Section III.

The Billing Process

The Financial Responsibility Section (Finance Section) in the HHSS Finance and Support Agency administers the billing process, but it relies on the Health Information Management Division (HIM) in the Health and Human Services Agency for documentation of each resident's medical condition and the services he or she receives from LRC.

Upon admission to LRC, new residents are interviewed by Finance Section staff members, who collect necessary financial information. The Finance Section stores this information in paper files and in the Automated Information Management System computer system (AIMS).

Finding: LRC's AIMS computer system has limited reporting capabilities.

During the course of this audit, we learned that the AIMS system has limited reporting capabilities. It lacks the capacity to calculate the total number of bills, or claims, submitted to third parties for each resident or for the whole population, or the number and amount of claims that are denied. LRC is in the process of replacing this system with a new one, Avatar, which we hope will improve such capabilities. However, our conversations with Finance Section representatives indicate that the Avatar system may also lack critical reporting capabilities. We discuss this concern further in Section V.

¹ The office that administers the billing process does maintain a notebook of memos and e-mails that address specific questions that have arisen about the billing process. However, many of these are very old and probably outdated.

As required by law, at the end of each month, the Finance Section calculates each resident's monthly charges, which are the sum of the per-day costs of the programs in which the resident participated and any additional services provided. Of these costs, program costs are by far the most significant.

After calculating a resident's monthly charges, the Finance Section determines who is responsible for payment. This determination is based on several factors. First, the Finance Section assesses whether the resident was committed to LRC by court order. Certain types of court orders dictate the entity that is liable for the cost of a resident's services. For example, if a court finds a resident incompetent to stand trial or guilty of a sexual crime, the state is fully responsible for the cost of the resident's care. Similarly, as we noted in Section I, if a court orders the resident committed to LRC to undergo a certain type of psychiatric evaluation, the county that ordered the evaluation is liable for its cost.

For residents whose care is not ordered by a court, the Finance Section determines whether any other third party, such as private insurance, Medicare, or Medicaid, is liable. If so, that party is billed. However, in most cases, payments from these entities do not cover the entire service cost. For any remaining cost, the Finance Section is required by law to attempt to collect payment from the LRC resident or his or her home county (*as defined in Section I, footnote 4*). Once all third-party sources have been exhausted, and the resident has paid the amount that LRC has determined he or she can afford, the state is liable and pays for the remainder of the service cost.²

Because the committee instructed us to focus on the collection of third-party payments, we describe the process for collecting these payments in more detail below.

Collection of Third-Party Payments

Third parties often refuse to pay (deny) a claim, either in whole or in part.³ However, in some instances, the Finance Section may still be able to collect the payment if it resubmits the claim. Consequently, the Finance Section must assess whether there is a reasonable likelihood that the claim would be paid if resubmitted.⁴

² LRC uses a formula to calculate monthly payments residents will make based on financial information given at the time they were admitted. See Title 202 NAC 1.

³ These denials come from private insurance companies, Medicare, and Medicaid. Because counties are required by law to submit payments on behalf of residents admitted to LRC, they cannot deny payment. Therefore, throughout the remainder of this report, we do not include counties in our analysis of denials by third parties.

⁴ Some types of denied claims have no chance of being paid. For example, LRC has no hope of collecting on claims that were denied because the resident did not, in fact, have coverage for mental health services or because the resident had exhausted his or her mental health coverage. In these cases, LRC would not resubmit the denied claim.

There are two types of denied claims that LRC considers for resubmission. First, a claim that was denied because it contained technical or clerical errors is likely to be paid if the error is corrected. According to representatives of the Finance Section, these types of denied claims are regularly corrected and resubmitted, and are paid unless another problem in the claim is identified.

Second, a third party may deny a claim because it believes that LRC provided a service that was not “medically necessary.” In most of the disagreements between LRC and a third party about medical necessity, the third party believes that LRC provided a higher level of service than the resident’s psychiatric condition required. In some of these cases, the claim will be paid if the Finance Section can provide documentation requested by the third party of the need for the service provided.

Another type of claim dispute that we included in the broad category of “medical necessity” involves third parties that require LRC to obtain their approval for the individual’s treatment. If LRC does not obtain prior approval, the third party may deny payment for services or charge LRC a penalty fee.

According to representatives of the Finance Section, when they decide to resubmit a denied claim for which the third party has challenged the medical necessity of the treatment provided, they must work with the Health Information Management (HIM) Division in the Health and Human Services Agency to provide the information requested by the third party. In these cases, the Finance Section forwards the denial letter to HIM staff members, who correspond with and send the requested information to the third party.

To determine the effectiveness and timeliness of HIM’s efforts to resubmit claims denied because the services provided were allegedly medically unnecessary, we asked to review the correspondence or other documentation for these cases. Surprisingly, we found that there was almost no documentation of what HIM sent to third parties or when they sent it.

Upon receipt of the requested information, the third party may pay the resubmitted claim or deny payment a second time. If the resubmitted claim is denied again, HIM representatives ask the physician who originally ordered the service whether or not to resubmit the claim again. According to HIM representatives, the physician makes the final decision.

To determine the reasons for which a denied claim would not be resubmitted, we asked to review documentation of these decisions.

Finding: LRC’s documentation relating to the resubmission of denied claims is inadequate.

Again, we found that there was almost no documentation of the reasons for these decisions.

The lack of documentation pertaining to resubmitted claims makes it impossible to fully assess LRC's efforts in this area. Because of this, we conclude that the documentation is inadequate.

SECTION III: Collection of Third-Party Payments

In Section II, we described the Lincoln Regional Center's (LRC's) billing process. Pursuant to the scope statement for this audit, in this section, we report the results of our analysis of LRC's efforts to collect third-party payments.

Claims and Payments

To begin our analysis, we asked the LRC's Finance Section to provide the total amount of third-party claims, payments, and denials in FY2002-03. The Finance Section provided the payment total, but it was unable to provide claim and denial totals, because AIMS does not calculate these figures.¹

Instead, the Finance Section gave us the claim and denial data for each resident, which we compiled and totaled. However, due to limitations in the data we received, our calculations also have limitations, and the results must be considered estimates.²

Nevertheless, we reviewed and analyzed a large quantity of information and are confident that our estimates fairly represent the actual figures. In addition, we verified our methods of data collection and review with Finance Section representatives who confirmed that they were reasonable and appropriate.

Third-Party Claims in FY2002-03

In FY2002-03, LRC filed 661 claims with third parties, which totaled over \$4.6 million.³ Of these, more than 225 were denied in full or in part. LRC collected almost \$1.9 million from third parties. However, over \$2.7 million was denied. These figures and breakdowns by payment source are shown in Table 2.

¹ As mentioned in Section II, the LRC's computer system cannot make these calculations.

² The potential shortcomings of the data result from the fact that: (1) the claims and denial information is not contained in a single database, and the information from each source did not always match precisely; and (2) although the Finance Section Staff members were responsive to our request, we were unable to confirm that we were given all available information.

³ LRC charges residents a daily rate, which varies by program. There may be additional charges for services that are not included in the program. Because the daily-rate charge is the most significant cost, we reviewed only the claims for those costs. In addition, we omitted pending claims from our analysis.

Table 2: Number, dollar value, and payment status of third-party claims submitted in FY2002-03.				
	<i>Insurance</i>	<i>Medicare A</i>	<i>Medicaid</i>	<i>Total</i>
Number of Claims	164	146	351 ⁴	661
Number of Denied Claims	129	37	59	225
Value of Claims	\$1,395,770	\$ 983,254	\$2,224,536	\$4,603,560
Value of Denied Claims	\$1,165,574	\$ 377,429	\$1,180,179	\$2,723,182
Payments Received	\$ 230,196	\$ 605,825	\$1,044,357	\$1,880,378

Source: Administrative data from the Lincoln Regional Center Finance Section; compiled by the Performance Audit Section.

Notes: Contains only claims for daily-rate costs. In addition, the figures do not include pending claims.

Resubmitting Denied Claims

As described in Section II, in some instances, the Finance Section may be able to collect payment if it resubmits a third-party claim that was initially denied. We also described the two types of denied claims that LRC considers for resubmission.

In this analysis, we reviewed one of those types of claims: those that were denied because the third party deemed the level of care the resident received to be medically unnecessary.⁵ That is, the third party did not believe the resident's diagnosed illness required the level of care he or she received. For these claims, we assessed whether LRC should have resubmitted the claims.

Following are the results of our analysis.

Private Insurance

In FY2002-03, LRC filed 164 private insurance claims, which were valued at nearly \$1.4 million. Of these, 129 were denied, either in full or in part, for a total of more than \$1 million. Of the 129 denied claims, we determined that 73, valued at more than \$620,000, had no chance of being paid if resubmitted. The remaining 56 claims, valued at more than \$400,000, were denied based on a disagreement about the level of service and might have been paid if LRC had resubmitted the claim with more documentation.

⁴ LRC filed 375 claims with Medicaid in FY2002-03, however, upon review, we found 24 claims contained technical errors and removed them from our analysis.

⁵ We excluded denied claims that resulted from clerical errors because Finance Section representatives told us that such claims are routinely corrected, resubmitted, and paid.

Finding: In 43% of the private-insurance files reviewed, there was no documentation indicating whether re-submission of the denied claims had been considered.

The 56 claims represent services provided to 16 residents. We reviewed these 16 residents' financial files to assess whether LRC considered resubmitting the denied claims. We found that in two residents' cases, LRC had resubmitted the claims and in seven cases, LRC decided not to resubmit the claims. In the remaining seven cases, we could not determine whether LRC had considered resubmitting the claims because there was no documentation in the files to indicate whether it had been considered.

Medicare A

Medicare is a federally-funded healthcare program, which provides healthcare coverage to people over 65, as well as people under 65 who have certain disabilities. Medicare A primarily covers the costs of rooms, meals, and nursing and other related services and supplies in either general or psychiatric hospitals.⁶

We found that in FY2002-03, LRC filed 146 claims for reimbursement, totaling over \$980,000. Of these, 37 claims were denied, either in full or in part, for a total of more than \$370,000. These figures are shown in Table 3.

Table 3: Medicare A Claims	
Number of Claims	146
Value of Claims	\$983,254
Medicare A Payments	\$605,824
Denied Claims	\$377,429

Source: Administrative data from the Lincoln Regional Center Finance Section; compiled by the Performance Audit Section.

Note: Contains only claims for daily-rate costs. In addition, the figures do not include pending claims.

To assess whether LRC resubmitted any of these claims, we asked the Finance Section to provide a list of residents for whom Medicare A claims were denied in FY2002-03. Of the 12 individuals on this list, we reviewed a sample of six.⁷ We found that, in four cases, the claims had not been resubmitted because the residents' Medicare benefits had been exhausted. The files for the two remaining residents lacked

⁶ In addition to Medicare A, some residents are covered by Medicare B. Medicare B pays for additional services, which include but are not limited to, certain psychological assessments and mental health and substance abuse services. Medicare B payments do not make up a large portion of LRC's reimbursement totals. However, we were told that the Hastings Regional Center and the Norfolk Regional Center collect a substantial amount of money from Medicare B. The committee may want to consider a review of Medicare B payments for a future audit.

⁷ We later discovered that six individuals with Medicare A claims denied in FY2002-03 were not included in the Finance Section's original list. However, we had already drawn our sample, and chose not to include these additional claims in our analysis.

the documentation necessary to enable us to determine whether the claims had been resubmitted.⁸

Medicaid

The Medicaid Program, funded by both state and federal governments, provides healthcare coverage to individuals who meet certain income-eligibility requirements. Most Medicaid recipients at LRC are adolescents.

In FY2002-03, LRC filed 351 Medicaid claims valued at more than \$2.2 million. Of the 351 claims filed, Medicaid denied 59, which were valued at almost \$1.2 million. These figures are shown in Table 4.

Table 4: Medicaid Claims	
Number of Claims	351
Value of Claims	\$2,224,536
Medicaid Payments	\$1,044,357
Denials	\$1,180,179

Source: Administrative data from the Lincoln Regional Center Finance Section; compiled by the Performance Audit Section.

Note: Contains only claims for daily-rate costs. In addition, the figures do not include pending claims.

To assess whether LRC considered resubmitting these claims, we asked the Finance Section to provide a list of residents for whom Medicaid claims were denied in FY2002-03. Of the 37 individuals on this list, we reviewed a sample of 17. We found that in two residents' cases, LRC resubmitted the claims, and in 12 cases, LRC decided not to resubmit the claims. In the remaining three cases, we could not determine whether LRC had considered resubmitting the claims because there was nothing in the files that indicated whether resubmission had been considered.⁹

⁸ In a 9 June 2004 telephone conversation, Finance Section staff defended the lack of documentation for these two files because they were still within the 18-month window to receive payment from the Medicare program.

⁹ In a 30 June 2004 e-mail, Finance Section staff stated that HIM staff had decided not to appeal these three cases.

SECTION IV: Billing-Process Management

In addition to requesting a description of the Lincoln Regional Center's (LRC's) billing process and an analysis of third-party payments, the scope statement for this audit instructed us to assess the working relationship between the Financial Responsibility Section in the Finance and Support Agency and the Health Information Management (HIM) Division in the Health and Human Services Agency. The scope statement also instructed us to determine whether sufficient oversight of the billing process exists. In response, we interviewed both finance-section staff members and HIM representatives and reviewed both financial and medical records. In this section we report on those issues.

Working Relationship Between the Finance Section and the Health Information Management Division

For the billing process to be effective, the Finance Section and HIM must cooperate. While the Finance Section administers the billing process, HIM maintains information about residents' medical conditions and treatment that is critical to the success of the Finance Section's collection efforts.

We identified two problems in the working relationship between these entities. First, during our case file review, we found almost no documentation of communication between the two entities. The absence of documentation was particularly troublesome with regard to third-party claims that had been denied but that might be paid if additional information were provided. As described in Section III, the pursuit of such claims involves both entities, and we expected to find documentation of the process used in deciding whether to pursue each claim. We were surprised that such documentation did not exist.

Finding: There is little documentation of communication between the two offices involved in the billing process.

Second, staff members in both offices told us they had problems getting the help they needed from staff members in the other office. We did not assess the specific allegations for accuracy and make no judgment about them. However, we believe it is a cause for concern that staff members believe that they are not getting the cooperation they need.

Finding: The offices involved in the billing process report difficulties in working together.

Sufficiency of the Oversight of LRC's Billing Process

As evidenced by the problems described above, we conclude that the oversight of LRC's billing process is insufficient. We believe that the root of the problem is that two entities involved in the process func-

Finding: LRC's oversight of the billing process is insufficient.

tion autonomously from one another and there is no entity with authority over the whole process.

While the Finance Section is under the jurisdiction of the HHSS Finance and Support Agency, HIM is under the jurisdiction of the HHSS Health and Human Services Agency. As the system is structured currently, unless the directors of the two agencies collaborate closely in ensuring the success of the bifurcated collection system, there is ongoing potential for the types of problems we have described. While we generally do not promote creating bureaucracy, we believe, in this case, it would be beneficial to have someone in a mid-level management position who has the authority to oversee the process in both agencies.

In Section V, we discuss our findings and make recommendations designed to improve the effectiveness of the billing process.

Part III

*Committee Findings and Recommendations
and
Fiscal Analyst's Opinion*

PERFORMANCE AUDIT COMMITTEE RECOMMENDATIONS

The Lincoln Regional Center's Billing Process

As the Legislative Performance Audit Committee (Committee) discussed the recommendations that follow, it took into account HHSS' statutorily required written response to the draft report concerning the Lincoln Regional Center's (LRC) billing process, as well as the testimony offered by the agency at the 10 September 2004 hearing on the report. Because the Committee believes that HHSS' handling of both its written response and its testimony raises issues that concern the effectiveness of the Legislature's performance audit process, it would like to offer some commentary about these issues prior to describing the recommendations it adopted.

During his hearing testimony, Steve Curtiss, then-director of the HHSS Finance and Support Agency, took issue with the findings of the Legislative Performance Audit Section (Section) regarding the effectiveness of LRC's billing system and LRC's management of patient files. (*See Section III of the Committee Report.*) Specifically, Mr. Curtiss disagreed with the Section's finding that, in many cases, the documentation in patients' financial files is inadequate in that it does not incorporate all the information necessary to enable auditors (and, ultimately, LRC managers) to judge whether LRC financial staff are doing enough in pursuing the payment of denied third-party claims.

Testifying that he had conducted his own review of denied claims,¹ Mr. Curtiss claimed that the Section's file review was inadequate and that it led to a poor and inaccurate analysis.² However, much if not all of the file data that Mr. Curtiss apparently relied on during his file review and at the hearing was "new" information: it was neither present in the patients' financial files when the auditors reviewed them, nor mentioned by the agency in its required response to the Section's draft report—a response that was issued in June.³

The timing of Mr. Curtiss' production of new evidence manifests a lack of respect for and cooperation with the Legislature's performance audit process and the Committee. The performance audit process is designed to make the performance of state agencies better and more cost-effective. In order to accomplish these goals, the process requires cooperation between the audit staff and the agency being audited.

The Committee wishes to make clear that it has no quarrel with the cooperation the Section received from the lower-level agency staff that it worked with. As is usually the case, these employees were most helpful during the audit. However, when Mr. Curtiss sent his written response to the Committee in June, he made no mention of any shortcomings in the Section's data analysis or the conclusions drawn based on that analysis. Instead, Mr. Curtiss wrote a cursory, rather dismissive response.

¹ On 1 September 2004, an HHSS Finance and Support manager e-mailed the Section asking for the names of the LRC patients included in the Section's file review.

² Transcript of hearing testimony, 10 September 2004, p. 24.

³ The Committee has no way of determining the legitimacy of the file data presented by Mr. Curtiss' at the hearing because it has not seen it. During the hearing, Mr. Curtiss told the Committee he would make the "new" information available to Section auditors. However, three weeks after the hearing, Mr. Curtiss resigned his position as head of the Finance and Support Agency to start a consulting firm. During the weeks between the hearing and Mr. Curtiss' resignation, the Section asked for the information several times, but Mr. Curtiss failed to produce it.

Then, when the Committee elected to hold a public hearing, he apparently went to work assembling data that he could use to attempt to discredit the audit.

We don't know what motivated Mr. Curtiss to disregard the earlier opportunity to respond to the report. However, the agency-response phase of the performance audit process is crucial, in that it enables the Section to determine whether or not the information it has reported and the analysis it has done are thorough and correct. Mr. Curtiss failed to provide a viable written response when required to do so, choosing instead to wait until the Committee decided to hold a hearing on the report. His actions in this regard are wholly unacceptable to the Committee.

In addition to the timing issue, by Mr. Curtiss' own admission, much of the data he brought to light at the hearing was probably not in the patient financial files reviewed by the Section during the course of the audit. Following the hearing, Mr. Curtiss told the lead auditor on the project that some of the information he presented may have come from LRC's medical files, rather than the financial files.⁴

In other words, in his own attempt to determine the effectiveness of the LRC billing process, even Mr. Curtiss could not rely on information in the patient financial files. Instead had to go to LRC's *medical files*, which are maintained separately from the financial files, in a different office—an office that the Section found does not have a viable working relationship with the office that maintains the financial files.⁵ (*See Section IV of the Committee report.*)

Finally, Mr. Curtiss also asserted that LRC does not need to develop comprehensive written policies to guide its billing process, as suggested by the Section, because the process is already “near-perfect.”⁶ However, information provided to the Section following the hearing suggests that Mr. Curtiss was either disingenuous or misinformed when making this assertion. Shortly after the hearing, the Section met with Dr. Barbara Ramsey, Chief Executive Officer of LRC, at her invitation.⁷ At the meeting, Dr. Ramsey shared with the Section a draft of proposed guidelines for LRC's billing process. The proposal had been developed by LRC in response to the work that the Section had done.

Despite Mr. Curtiss' eleventh-hour attempt to discredit the Section's data analysis and recommendations, the Committee has no reason to believe that they were not on target. Following are the Committee's final recommendations.

Findings		Recommendations
1	LRC's written guidelines for the billing process are inadequate. Neither the Finance Section (overseen by the HHSS Finance and Support Agency) nor the Health Information Management (HIM) Division (overseen by	LRC should create and implement internal policies that will provide guidelines for both entities involved in the billing process. We recommend that the HHSS Finance and Support

⁴ This conversation occurred directly after the 10 September 2004 hearing, at Mr. Curtiss' invitation. Based on nature of the “new” information Mr. Curtiss presented to the Committee at the hearing, it appears that the data did, in fact, come from medical files.

⁵ The HHSS Finance and Support Agency's LRC Finance Section manages patient financial files; the HHSS Services Agency's LRC Health Information Management Division (HIM) manages patient medical files.

⁶ Transcript of hearing testimony, 10 September 2004, pg. 47.

⁷ The meeting took place on 22 September 2004.

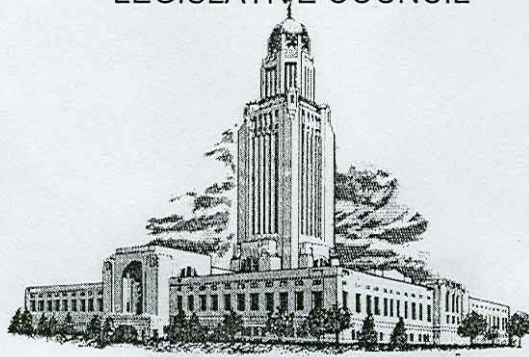
Findings	Recommendations
<p>the HHSS Services Agency) has comprehensive written policies that describe and guide the billing process. The billing process is complicated, and we believe that using written policies as a management tool would help increase effectiveness.</p>	<p>Agency and the Services Agency approve the proposed guidelines Dr. Ramsey presented to the Section at the 22 September 2004 meeting (or a very similar version), and that the Finance Section and HIM implement the policies.</p>
<p>2 LRC's computer system, AIMS, is inadequate. The Finance Section was able to report the total dollar value of third-party payments received in FY2002-03. However it could not report the total dollar value of the claims submitted and denials received, or the total number of those claims and denials. We believe this problem stems primarily from the reporting inadequacies of its database, AIMS.</p> <p>AIMS was not designed to report the figures described above, either for individual residents or the LRC population as a whole. LRC is in the process of replacing AIMS with a new database, Avatar. We hope this new database will improve upon the limited reporting capabilities that are characteristic of AIMS. However, based on conversations with Finance Section representatives, we are concerned that this will not be the case.</p> <p>During the audit, we recommended to Finance Section staff that they create a spreadsheet to track claim, payment, and denial information totals. They did so for the private insurance entries and agreed it was helpful to their process.</p>	<p>If the reporting capability of its computer system continues to be deficient, the Finance Section should maintain spreadsheets to record the dollar amounts of third-party claims, payments, and denials. All of this information should be kept in the aggregate and on a per-resident basis. In addition, the Finance Section should use spreadsheets to record the reasons for denials by using an internally created coding system, even if the development and use of such a coding system would require input from HIM.</p> <p>The Committee may consider introducing legislation that requires the Finance Section to track and compile claim, payment, and denial information totals, in the aggregate and on a per-resident basis, and report them to the Legislature on an annual basis.</p>
<p>3 HIM representatives do not maintain records of their correspondence with third parties. Neither copies of the correspondence, nor references to the medical information sent to third parties, is kept on file. This is wholly unacceptable.</p> <p>In addition, HIM's documentation of physician decisions regarding the resubmission of denied claims is inadequate. For example,</p>	<p>We believe copies of the correspondence between HIM and third parties should be kept on file. In addition, conversations between HIM staff and physicians regarding the resubmission of denied claims should be documented and kept on file.</p> <p>We recommend that HIM implement the billing and documentation policies Dr. Ramsey showed to staff auditors on 22 September 2004.</p>

Findings		Recommendations
	conversations between physicians and HIM representatives relating to the resubmission of denied claims are not well-documented.	
4	<p>There is an apparent lack of communication between the Finance Section and HIM regarding the billing process. Based on conversations with both offices' staff members and a shortage of documentation, we believe communication between the two offices needs improvement. For the billing process to be as effective as possible, it is imperative that staff members from both offices feel confident in asking one another for assistance.</p>	<p>LRC should develop internal policies that encourage communication and cooperation between the two offices.</p> <p>We recommend that the Finance Section and HIM implement the billing and documentation policies Dr. Ramsey proposed on 22 September 2004.</p>
5	<p>Oversight of the billing process is insufficient. We believe the root of the billing-process inadequacies described above is the fact that the two offices involved in the billing process function autonomously from one another, and there is no entity with authority over the whole process. Because neither office has oversight, the process cannot be as effective as possible.</p> <p>The Finance Section hired a staff member in 2003 who will review the billing processes used by the regional centers. We find this development encouraging. However, it does not go far enough in that the new staff member can only recommend ways to improve the billing process; she has no authority to enforce her recommendations.</p> <p>The fundamental problem that we see is a result of the fact that the Finance Section falls under the ultimate jurisdiction of the HHSS Finance and Support Agency, while HIM is under the HHSS Health and Human Services Agency. There is essentially no entity or person who can effectively ensure the cooperation of the two agencies and their subordinate offices.</p>	<p>We believe that the structural deficiency described in Finding 5 could be addressed by creating a mid-level management position that would have the authority to oversee and coordinate the billing process and to ensure that the Finance Section and HIM are working effectively together. Because of the complexity of the HHSS management structure, we are not comfortable describing where such a position would fit into the chain of command. However, we believe that the agencies, working together, should come up with a revised structure that would accomplish what we are recommending.</p> <p>We would like to emphasize that this recommendation should not be interpreted as granting either HHSS agency dictatorial authority over the other; this should not become a territorial dispute. We recommend that the two HHSS agency directors communicate and cooperate with one another, and if necessary, compromise to create a viable solution to this problem.</p>

State of Nebraska

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MAY 24 2004

LEGISLATIVE RESEARCH

MEMO

TO: Cynthia Johnson

FROM: Michael Calvert and Sandy Sostad

RE: Performance Audit – Billing Process - Lincoln Regional Center

DATE: May 21, 2004

This memo is in response to your request of May 18th asking for our opinion as to whether the recommendations from the performance audit of the Lincoln Regional Center can be implemented with existing appropriations.

It appears to us that recommendations for Findings 1 and 4 regarding the implementation of internal policies relating to written guidelines for the billing process and encouraging communication and cooperation between the offices involved in the process can be accomplished with existing staff and resources of the health and human system agencies. The recommendation pursuant to Finding 5 to establish a mid-level management position with authority to oversee staff involved in the billing process will have a fiscal impact if a new employee is retained. However, it is possible that the person hired in 2003 to review the billing process could be given additional authority or the responsibility could be assigned to an existing staff member.

Recommendations pursuant to Findings 2 and 3 regarding inadequate documentation of the denial and resubmission of claims and the accurate reporting of the total number and value of claims submitted and denials received will have a fiscal impact in terms of implementation. The least costly alternative would be to develop spreadsheets to track the history of claims and quantify claims, payments and denials. It is assumed the use of this technology could be accomplished with existing staff and resources. If a new computer system or database is employed to implement the recommendations, then there could be a substantial fiscal impact depending upon the design of the system.

The maintenance of files documenting correspondence between the HHS agencies and third-parties and decisions of staff and physicians regarding claims will in all probability increase the workload of persons involved in the billing process, but it is assumed that no additional staff will be necessary to implement this recommendation.

Our overall opinion is that the recommendations of the performance audit can be implemented with the existing staff and resources of the HHS agencies. There may be additional expenses and an increased workload for the HHS system to initially implement the recommendations, but it is likely that the refinement of the billing process will result in an increase in revenue received from third parties in the future.

Part IV

Background Materials

BACKGROUND MATERIALS

The “background materials” provided here are materials (in addition to the Section’s report) that were available to the Committee when it issued the findings and recommendations contained in Part III of this report. They include:

- the Section’s findings and recommendations (provided for context);
- the agencies’ response to a draft of the Section’s report;
- the Section Director’s summary of the agencies’ response;
- a letter from the Committee Chair to the agencies regarding the Committee hearing; and
- a summary of testimony given at the public hearing held by the Committee.

Section Draft Findings and Recommendations

We identified problems involving four aspects of the LRC billing process: **a lack of written guidelines** designed to describe and guide the billing process; **insufficient documentation** relating to third-party billings; **ineffective communication** between the HHSS Finance and Support Agency's Financial Responsibility Section (Finance Section) and the HHSS Health and Human Services Agency's Health Information Management Division (HIM), which are the two offices involved in the billing process; and **inadequate oversight** of the process as a whole.

Based on our research, we conclude there are potentially significant reimbursement amounts that may go uncollected if the system responsible for collection is not functioning well. As the system stands right now, however, we cannot determine whether money due the state is going uncollected because the documentation that would allow us to arrive at such a determination is inadequate.

Following are our findings and recommendations relating to each of the four areas noted above.

Guidelines

Finding 1: LRC's written guidelines for the billing process are inadequate.

Discussion: Neither the Finance Section nor HIM has comprehensive written policies that describe and guide the billing process. The billing process is complicated, and we believe that using written policies as a management tool would help increase effectiveness.

Recommendation: *LRC should create and implement internal policies that will provide guidelines for both entities involved in the billing process.*

Documentation

It is difficult for us to assess how effective the Finance Section and HIM are in resubmitting denied claims and collecting payments associated with resubmitted claims because neither appears to document the necessary information effectively. We recognize that agency staff members have many other responsibilities that consume their time. However, in order to determine the effectiveness of the billing process and to manage and make improvements in it, such documentation must be available, either in paper or electronic form.

Finding 2: LRC's documentation relating to claims that were initially denied, and subsequently resubmitted, is inadequate.

Recommendation: The specific recommendations associated with this general finding are noted below.

Finance Section

Finding 3: LRC's computer system, AIMS, is inadequate.

Discussion: The Finance Section was able to report the total dollar value of third-party payments received in FY2002-03. However it could not report the total dollar value of the claims submitted and denials received, or the total number of those claims and denials. We believe this problem stems primarily from the reporting inadequacies of its database, AIMS.

AIMS was not designed to report the figures described above, either for individual residents or the LRC population as a whole. LRC is in the process of replacing AIMS with a new database, Avatar. We hope this new database will improve upon the limited reporting capabilities that are characteristic of AIMS. However, based on conversations with Finance Section representatives, we are concerned that this will not be the case.

During the audit, we recommended to Finance Section staff that they create a spreadsheet to track claim, payment, and denial information totals. They did so for the private insurance entries and agreed it was helpful to their process.

Recommendation: *If the reporting capability of its computer system continues to be deficient, the Finance Section should maintain spreadsheets to record the dollar amounts of third-party claims, payments, and denials. All of this information should be kept in the aggregate and on a per-resident basis. In addition, the spreadsheets should be used to record the reasons for denials by using an internally created coding system, even if the development and use of such a coding system would require input from HIM.*

HIM

Discussion: HIM representatives do not maintain records of their correspondence with third parties. Neither copies of the correspondence, nor references to the medical information sent to third parties, is kept on file. This is wholly unacceptable.

In addition, HIM's documentation of physician decisions regarding the resubmission of denied claims is inadequate. For example, conversations between physicians and HIM representatives relating to the resubmission of denied claims are not well-documented.

Recommendation: *We believe copies of the correspondence between HIM and third parties should be kept on file. In addition, conversations between HIM staff and physicians regarding the resubmission of denied claims should be documented and kept on file.*

Communication

Finding 4: There is an apparent lack of communication between the Finance Section and HIM regarding the billing process.

Discussion: Based on conversations with both offices' staff members and a shortage of documentation, we believe communication between the two offices needs improvement. For the billing process to be as effective as possible, it is imperative that staff members from both offices feel confident in asking one another for assistance.

Recommendation: *LRC should develop internal policies that encourage communication and cooperation between the two offices.*

Oversight

Finding 5: Oversight of the billing process is insufficient.

Discussion: We believe the root of the billing-process inadequacies described above is that the two offices involved in the billing process function autonomously from one another, and there is no entity with authority over the whole process. Because neither office has oversight, the process cannot be as effective as possible.

The Finance Section hired a staff member in 2003 who will review the billing processes used by the regional centers. We find this development encouraging. However, it does not go far enough in that the new staff member can only make recommendations on ways to improve the billing process; she has no authority to enforce her recommendations.

The fundamental problem that we see is a result of the fact that the Finance Section falls under the ultimate jurisdiction of the HHSS Finance and Support Agency, while HIM is under the HHSS Health and Human Services Agency. There is essentially no entity or person who can effectively ensure the cooperation of the two agencies and their subordinate offices.

Recommendation: *We believe that the structural deficiency described above could be addressed by creating a mid-level management position that would have the authority to oversee and coordinate the billing process and to ensure that the Finance Section and HIM are working effectively together. Because of the complexity of the HHSS management structure, we are not comfortable describing where such a position would fit in the chain of command. However, we believe that the agencies, working together, should come up with a revised structure that would accomplish what we are recommending.*



June 15, 2004

Cynthia Johnson, Director of Research
Performance Audit Section
Nebraska Legislative Research Division
PO Box Box 94945, State Capitol
Lincoln, NE 68509-4945

RECEIVED

JUN 15 2004

LEGISLATIVE RESEARCH

Dear Ms. Johnson:

Below are the Health and Human Services System (HHSS) responses to the Performance Audit Section's draft report in connection with the audit of the Lincoln Regional Center's billing process.

Finding #1 - LRC's written guidelines for the billing process are inadequate.

Written guidelines from several sources are used by Financial Responsibility (FR) for the billing process, e.g., state statutes, UB-92 Manual, Part A and Part B Hospital and Reimbursement Manuals, State Medicaid Manuals, etc. Inpatient billing is an automated process in AIMS based on the census, rates and third and fourth party information obtained and entered by the FR staff. The payer source and type of services billed in AIMS determines the billing form used. These same references are used for billing outpatient and adolescent residential services.

In light of the scheduled implementation of the new AVATAR billing system, the HIM staff and Finance Section staff will jointly review their current use of billing guidelines and policies and look for opportunities to make them clearer. Any guideline or policy changes will be adopted by both Lincoln Regional Center and the Financial Responsibility Division to ensure that staff in both areas are held accountable for the policy and process.

Finding #2 & Finding #3 - LRC's computer system, AIMS, inadequate.

The Finance Section agrees with the maintenance of third-party claims, payments, and denial information. This information can be found in the current AIMS Billing System and will be available in the new AVATAR system as well. The Finance Section will ensure that coding is established and used in the new system to track this information.

HIM staff will review and improve if necessary its policies pertaining to the processing of denied claims and documentation requirements. An audit will be conducted to insure that documentation is routinely provided on all resubmission of denied claims. The audit will be conducted by the LRC quality assurance person.

Finding #4 - There is an apparent lack of communication between the Finance Section and HIM regarding the billing process.

The HIM staff and Financial Responsibility will meet to determine critical points of contact and further determine if better documentation of correspondence between the divisions concerning these points of contact is needed.

Finding #5 - Oversight of the billing process is insufficient.

HHSS agrees with the substance of this recommendation and is in the process of determining the best way to address this issue including the possibility of hiring an administrator that would have the responsibility and authority to oversee and coordinate the billing process of both the Finance Section and HIM.

Sincerely,



Stephen B. Curtiss, Director
Department of Health and Human Services Finance and Support



Nancy Montanez, Director
Health and Human Services

DIRECTOR'S SUMMARY OF AGENCY RESPONSE

On 15 June 2004, the Health and Human Services System's (HHSS's) Finance and Support Agency and HHSS' Services Agency, submitted a response to a draft of the Performance Audit Section's report prepared in conjunction with this audit. Neb. Rev. Stat. sec. 50-1210 requires the Section Director to "prepare a brief written summary of the response, including a description of any significant disagreements the agency has with the section's report or recommendations." The director's summary of the response follows.

Section Recommendations:

HHSS' Finance and Support Agency and Services Agency (the agencies) generally agree with the section's recommendations, and each agrees to implement changes that reflect our recommendations. However, we would like to address a few specific issues in the agencies' response.

Finding 1: *We initially recommended that LRC create and implement comprehensive billing policies. The agencies' directors responded by saying they would make an effort to make the billing policies clearer for staff members.*

We believe that the agencies should compile summaries of the applicable policies, or at least references to them, in one manual so that staff members, especially new staff members, can easily locate essential billing policies.

More to the point, we are concerned about the interaction between the agencies' staff members as they use the billing process. We believe each agency should have written policies that define its role in the billing process and explain how and when the two agencies should interact. While we recognize the value of institutional knowledge, we do not believe it should replace up-to-date and comprehensive written policies.

Findings 2 and 3: *We initially recommended that, because of inadequacies in the AIMS computer system, finance section staff members should maintain spreadsheets to track and compile the total amounts of claims submitted for reimbursement and the amounts of claims denied. The agencies' directors responded by assuring us that AVATAR, LRC's new computer system, will be able to track this information.*

We acknowledge in our audit that AIMS contains payment totals and some billing and denial information, as AVATAR most likely will. However, AIMS has inadequate reporting capabilities; it is unable to compile and report the total amounts of claims and denials for individuals, as well as for the LRC population. We remain concerned that AVATAR will have the same weaknesses as AIMS.

When we follow-up on LRC's implementation of our recommendations, we will ask to see AVATAR-generated reports, which provide the total amounts of claims, payments, and denials for individuals and for the LRC population. Depending on the needs of finance section staff and the realistic capabilities of AVATAR, we believe the daily use of spreadsheets to compile resident billing information would help staff manage the voluminous paperwork they receive and, as a result, create a more efficient billing process.

Finding 4: *We initially recommended, in conjunction with Recommendation 2, that communication between the agencies' staff members needed improvement and should be documented. The agencies' directors responded by saying each would determine critical points of contact and further determine if better documentation was needed.*

We reiterate our initial recommendation that documenting communication (e.g., paper and/or electronic copies of e-mails primarily) between the agencies' staff members is critical to ensure an effective billing process. Again, while we recognize the value of institutional knowledge, we do not believe it should replace up-to-date and comprehensive written policies.

Finding 5: *We initially recommended that HHSS create a mid-level management position that would have the authority to oversee and coordinate the billing process. The agencies' directors agreed with the need for oversight and coordination and are in the process of finding a solution, which includes the possibility of hiring an administrator.*

We are pleased that the agencies' directors are considering ways to address this issue.

Legislative Performance Audit Committee

Committee Members:

Senator Chris Beutler, Chair
Senator Marian Price, Vice Chair
Speaker Curt Bromm
Senator Pam Brown
Senator Pat Engel
Senator Vickie McDonald
Senator Roger Wehrbein

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Section Staff:

Cynthia Johnson, Director
Dan Augustyn, Legal Counsel
Martha Carter, Analyst
Angela McClelland, Analyst
André Mick, Analyst
Sandy Harman, Committee Clerk

2 September 2004

Steve Curtiss, Director
HHSS Finance and Support Agency
P.O. Box 95026
Lincoln, NE 68509-5026

Nancy Montanez, Director
HHSS Services Agency
P.O. Box 95044
Lincoln, NE 68509-5044

Dear Mr. Curtiss and Ms. Montanez:

As you know, the Legislative Performance Audit Committee (committee) is scheduled to hold a hearing September 10, 2004, on two audits conducted by the Legislative Performance Audit Section (section).

In the report prepared in conjunction with one of the audits (*The Lincoln Regional Center's Billing Process*), the section recommended that LRC create and implement internal policies to guide the staff of both the Health Information Management Section (HIM) and the Financial Responsibility Section (finance section) with regard to the billing process. The section's concern was twofold: 1) that the written guidelines describing how to process claims and denials were inadequate, and 2) that the HIM and finance section staff received too little instruction concerning their respective responsibilities and how they should interact.

Your response indicated that you would jointly review your billing guidelines and policies to look for ways to make them clearer. At the hearing, the committee would like you to discuss any policy improvements you are considering.

Second, the section questioned whether HHSS's new computer system, Avatar, will be a useful reporting tool. While Avatar will be able to report the total amount of payments received, the section questions whether Avatar will be able to report either the total number of claims (and their value) submitted for reimbursement, or the number of denials (and their value), in the aggregate and on a per-person basis. The section recommended that if Avatar is unable to report these totals, finance section staff should keep spreadsheets to track this information. In your response to the section's recommendation, you assured them that Avatar, through an HHSS-established coding system, will be able to track this information. At the hearing, the committee would like to review Avatar printouts that convey this aggregate information (preferably from 1 July 2004 forward). If Avatar is un-

able to report this documentation, the committee would like to review any spreadsheets the finance section has produced to track this information.

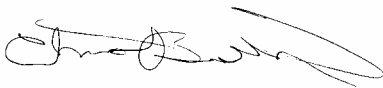
Third, the section also found that the documentation relating to the resubmission of denied claims is inadequate. For example, HIM representatives neither maintain records of their correspondence with third parties, nor do they adequately document physician decisions regarding the resubmission of denied claims. The section recommended that copies of the correspondence between HIM and third parties be kept on file. In addition, conversations between HIM staff and physicians regarding the resubmission of denied claims should be documented and kept on file. Your response indicated that HIM staff would review, and *if necessary*, improve the procedures pertaining to the processing of denied claims and documentation requirements. The section believes, based on the documentation (or the lack thereof) found during the audit, that improvements *are* necessary. At the hearing, the committee would like you to discuss any procedural improvements you are considering.

The section also found it troubling that HIM and finance section staff did not feel comfortable communicating with one another, and the section believes that internal procedures should be created to help ensure effective communication. In your response, you indicated that HIM and finance section staff would meet to determine critical points of contact and further determine if better documentation of correspondence between the divisions is necessary. The section believes that better documentation of communication between the finance section and HIM is necessary. At the hearing, the committee would like you to discuss any improvements you are considering.

Finally, the section found that oversight of the billing process is insufficient. The section recommended that HHSS create a midlevel management position to oversee how HIM and the finance section use the billing process. In your response, you indicated that you agreed with the substance of this recommendation and would consider ways to address this issue. At the hearing, the committee would like to discuss any plans you are considering to address this issue.

If you have any other questions about the committee's concerns, please contact me or André Mick at 471-0074.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris Beutler", written over a horizontal line.

Chris Beutler, Chairperson
Legislative Performance Audit Committee

cc. Members of the Performance Audit Committee

Summary of Testimony Received During the Lincoln Regional Center Hearing

On 10 September 2004 the Legislative Performance Audit Committee (Committee) held a hearing on two performance audits—*The Lincoln Regional Center’s Billing Process* and *The Nebraska Medicaid Program’s Collection of Improper Payments*—recently conducted by the Legislative Performance Audit Section (Section).

The Committee Chair, Senator Chris Beutler, opened the hearing with comments summarizing the events leading to the hearing and expressing hope that the Health and Human Services System (HHSS) agencies and the Committee could have an open dialogue resulting in agreement on how to resolve issues the Section discussed in its audit reports.

Ms. André Mick, lead auditor for the Lincoln Regional Center (LRC) performance audit, summarized the main findings and recommendations made as a result of the audit. Ms. Mick stated the Section had determined that LRC’s documentation relating to denied claims was inadequate. In the Section’s opinion, LRC should track and record—either through Avatar (its new computer system) or Excel spreadsheets—the dollar amounts of third-party claims, payments, and denials. All of this information should be kept in the aggregate and on a per-resident basis in order to improve the billing process. In addition, the Section recommended that HHSS develop comprehensive written policies that describe the billing process and encourage communication among staff.

Steve Curtiss, Director of the HHSS Finance and Support Agency,¹ also representing the HHSS Services Agency, testified next. In his testimony, Mr. Curtiss took issue with the Section’s findings regarding the effectiveness of LRC’s billing system and LRC’s management of the patient files that document the collection of third-party payments that may be due the state but that have been denied. (*See Section III of the Committee Report.*) Stating that he had conducted his own review of denied claims, Mr. Curtiss claimed that the Section did an inadequate file review, which resulted in a poor and inaccurate analysis. In addition, he asserted that it was unnecessary for HHSS to develop any new policies regarding LRC’s billing process because it was already “near-perfect, if not perfect.”

In taking questions from the Committee, Mr. Curtiss did not deny that HHSS is unable to report the number and amount of third-party

¹ On 2 October 2004, Mr. Curtiss announced his resignation as head of the HHSS Finance and Support Agency. He left the agency to form a private consulting firm.

claims and denials. In addition, when questioned about where he located the information he was using to dispute the Section's findings, Mr. Curtiss conceded that some of it may not have been in the financial files at the time the Section conducted its file review. Senator Beutler asked Mr. Curtiss if the Section could review the additional file data he had brought to the hearing. Mr. Curtiss agreed to provide the data to the Section.²

Mr. Miles Kimmel, a former mid-level manager for the HHSS Finance and Support Agency at LRC, was the final testifier. He asserted that as a former manager he had instituted "written policies" that clearly explained how the Finance Section should collect third-party reimbursements.³ In addition, Mr. Kimmel asserted that keeping an Excel spreadsheet of bills, payments, and denials would not be helpful.⁴

² Immediately following the hearing, Mr. Curtiss told Ms. Mick that some of the file data he was using "may not have" come from patients' financial files, which were the files the Section examined in doing this audit. Rather, he indicated that the data may have come from patient medical files, which the Section did not include in its file review. The Section attempted to obtain the promised file data from Mr. Curtiss in the weeks following the hearing, with no success. Three weeks after the hearing, Mr. Curtiss announced his resignation. (See footnote 1, above.)

³ During the audit, the Section found the "written policies" Mr. Kimmel referred to in his testimony; they were a collection of e-mails he sent to employees in the early and mid- 1990s. (See Section II of the report, footnote 1.)

⁴ Prior to leaving the agency, in an e-mail dated 25 August 1993, Mr. Kimmel had instructed Finance Section staff to stop collecting financial information as it pertained to third-party claims, payments, and denials. Because the Section needed access to such information, they asked Finance Section staff to create a spreadsheet that would enable them to track financial information about private insurance claims, payments, and denials. In a telephone conversation on 10 June 2004, Finance Section staff told the Section that creating such a spreadsheet was, indeed, helpful because they could more easily manage patient accounts. Eventually, the Finance Section could use the spreadsheet to conduct limited trend analyses to see how much it was billing and collecting, and if necessary, make changes to procedures to maximize amounts collected.