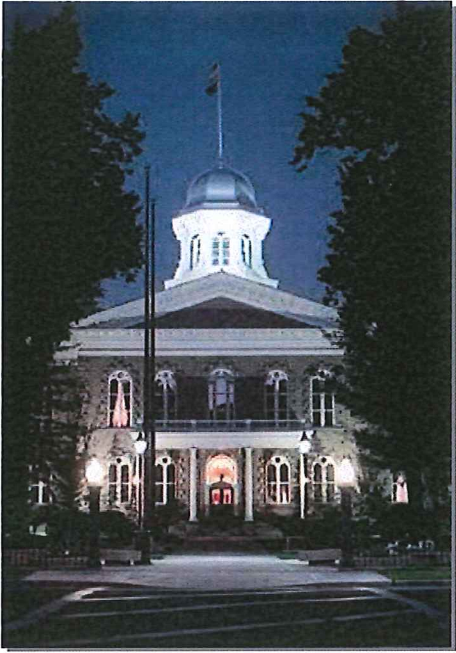

State of Nevada
Department of Administration
Division of Internal Audits

Audit Report

Department of Health and Human Services
Division of Mental Health and Developmental Services
Mental Health Services

Report No. 10-06
June 2010

EXECUTIVE SUMMARY
Division of Mental Health and Developmental Services

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Supervisors should more closely monitor doctor attendance. Based on our review, doctors have not been working their full shift. Supervisors could more closely monitor doctor's attendance by reviewing the electronic access control system and timesheets. We estimate lack of attendance amounted up to $1.7 million of doctors' time absent from the Rawson-Neal Hospital in fiscal year 2009.

Outpatient Doctor Productivity..page 9

Supervisors should more closely monitor doctor productivity. The Division does not monitor doctor productive services. Outpatient doctor productivity is affected by: 1) data entry of client care and documentation in the Division's electronic medical records and billing system and 2) attendance. Supervisors can monitor doctor productivity through a 2-step process:

Step 1 – Review productivity by comparing timesheets and productive service hours; if accurate and a productivity issue remains, move to step 2.

Step 2 – Evaluate implementing an electronic access control system.

By monitoring productivity to ensure doctors achieve the 62 percent standard, the State will benefit by up to $672,000 annually in increased doctor efficiencies.

Evaluate Productivity Standards..page 12

Evaluating productivity against current industry standards will help the Division determine if it has appropriate expectations for its doctors. The outpatient doctor productivity standard of 62 percent has not been evaluated for over ten years. Another State entity, UNR's Medical School Associates, has an 80 percent productivity standard for outpatient clinic doctors established by the Medical Group Management Association, a professional organization for managers and leaders of medical group practices.

Evaluate and Include the Productivity Standard in Doctor Contracts..........page 13

Contract doctors should have a higher productivity standard than State employed doctors. Currently, State and contract doctors have the same productivity standard of 62 percent. This standard is based on doctors being required to perform 1,300 annual productive hours. State doctors are paid for 2,080 hours annually, including sick, annual, or holiday leave. After removing leave and holidays, State doctors work 1,752 hours annually. Contract doctors should have a higher productivity standard because they are not paid for leave or holidays. If contract doctors were required to perform comparable productive services, we estimate the productivity standard would be about 74 percent.

We estimate the Division could increase productive time for some outpatient contract doctors by at least $122,000 if it adopted a higher standard.

Establishing a productivity standard in contracts will allow Division supervisors to better evaluate doctor performance. The Division does not have a productivity standard stated in its contracts for doctors. A standard will help clarify the Division's expectations for its contract doctors.

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Supervisors should review doctor treatment entries. Our review shows some productive services are not being entered into the Division's electronic medical records and billing system. In 2009, hospital doctors only recorded 20 percent of client psychiatric evaluations. This amounted to about $130,000 in missed billings.

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The Division should ensure its mental health professionals complete the Medicare credentialing process so the two State hospitals can fully bill for services. The Division is not fully reimbursed for services because some mental health professionals are not credentialed by Medicare for billing purposes. We estimate the Division can enhance Medicare hospital billing by up to $280,000 by credentialing mental health professionals.

Obtain Pre-authorization to Bill for Medicare Clients Who Have Exhausted Their Benefits..page 18

The Division should obtain pre-authorization for reimbursement from Medicaid to cover costs for co-eligible Medicare clients who have exhausted their psychiatric care benefits. Clients exhaust their Medicare psychiatric benefits after 190 days of hospital care (psych exhaust). The Division has not been obtaining the pre-authorization for reimbursement from Medicaid prior to submitting the claim. The Division can enhance revenues from psych exhaust clients by up to $92,000 annually with an approved pre-authorization.

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The Division should develop an IT plan. The Division does not have a current plan for IT acquisition and sustainment. The IT Governance Institute estimates that as much as 20 percent of IT expenditures may be wasted without a plan. The Division could potentially reduce costs by up to 20 percent annually with an IT plan.

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The Division should work with DoIT to accomplish a TIR to review and assess its electronic medical records and billing system. A more capable system would allow staff to be more efficient, increase doctor productivity, and help the Division more fully bill for its services. We estimate this could free up to ten percent in employee time annually. The Division will need to evaluate the gain in efficiency with the costs for upgrading or replacing the existing system.

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INTRODUCTION

At the direction of the Executive Branch Audit Committee, we conducted an audit of the Division of Mental Health and Developmental Services (Division). Our audit addressed the following four questions:

- ✓ What is the Division's role?
- ✓ What services must the Division provide?
- ✓ Is the State the proper level of government to provide these services?
- ✓ If State government is the appropriate level of government, is the Division carrying out its duties efficiently and effectively?

Our audit focused on the productivity of the Division's doctors, enhancing billings for psychiatric care funded by the State, and the Division's information technology system.

Division's Role and Public Purpose

The Division is within the Department of Health and Human Services. The Division works with individuals (clients), families, advocacy groups, agencies, and communities to help Nevadans challenged with mental illness or developmental disabilities live as independently as possible.

The Division performs functions such as:

- Mental health services for clients with mental illness.
- Developmental services for clients with developmental disabilities.
- Substance abuse prevention and treatment services for clients with drug and alcohol dependency.

Our audit focused on the Division's mental health services. The Division operates 24 outpatient clinics throughout the State and two urban area hospitals providing psychiatric services for Nevadans.

- Outpatient clinics provide assessment, care, treatment and education. The clinics also provide counseling and psychotherapy. Services begin with an assessment to identify individual problems and resources, set treatment goals, and plan treatment.
- The hospitals provide psychiatric inpatient treatment for adults with serious mental disorders who have been assessed dangerous to themselves or others. Patients are treated by a team consisting of

psychiatrists, nurses, other psychiatric professionals[1], dieticians, and benefit coordinators. Treatment programs are individualized to suit the needs of each client admitted to the hospital. The goal is to stabilize the client and move them to outpatient treatment services if continued care is necessary.

A patient observation unit (POU) is located in each hospital; however it is not part of inpatient services. Clients are sent to the POU for observation to determine if they should be admitted to the hospital. Clients generally stay in the POU 1 – 3 days before being admitted to the hospital or released. In many cases, clients are referred to the agency's outpatient services for continued treatment.

The Division's mental health services are coordinated through three agencies:

- Northern Nevada Adult Mental Health Services (NNAMHS), Reno, operates 2 outpatient clinics and 1 hospital. The Dini-Townsend Hospital is licensed as a 70-bed facility that includes a 10-bed POU. The hospital is currently staffed for 50 beds.

- Southern Nevada Adult Mental Health Services (SNAMHS), Las Vegas, operates 4 outpatient clinics and 1 hospital. The Rawson-Neal Hospital is licensed as a 289 bed facility that includes a 30-bed POU. The hospital is currently staffed for 212 beds.

- Rural Services (Rurals), Carson City, operates 19 outpatient clinics throughout Nevada, excluding Las Vegas/Clark County and Reno.

Billing for Services

The Division bills clients, Medicare, Medicaid, and private insurers for the psychiatric services it provides:

- Clients who do not have insurance benefits are billed on a sliding fee scale. The sliding fee is based on the client's ability to pay.

- Medicare is a federal health insurance program for people age 65 or older and people under age 65 with certain disabilities. There are 3 components to Medicare coverage:
    1. Part A Hospital Insurance – helps cover inpatient care in hospitals and skilled nursing facilities. Beneficiaries must meet certain conditions to get benefits.
    2. Part B Medical Insurance – helps pay for covered services and supplies when they are medically necessary.

[1] Other psychiatric professionals include psychologists and licensed clinical social workers.

3. Prescription Drug Coverage – helps pay for the cost of medication. Coverage is provided by private companies and beneficiaries choose the plan.

- Medicaid is a state administered program and each state sets its own guidelines for eligibility and services. In general, the federal government splits costs for Medicaid with the states on 50/50 bases. Medicaid is available to certain low-income individuals and families who fit into an eligibility group recognized by federal and state law. Many groups are covered by Medicaid, although certain requirements must be met, such as low income, age, pregnancy, and disability.

- Clients with private insurance are encouraged to get services from their insurance plan's preferred providers. In some cases, particularly in rural clinics, clients with private insurance are treated by the Division.

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For fiscal year 2010, the Division's budget is $326 million with 1,710 full-time employees. Mental health services comprise just over $142 million, or almost 44 percent of the Division's budget.

The State has determined the Division of Mental Health and Developmental Services will operate facilities to provide services for Nevadans with mental illness, addiction disorders, developmental disabilities, and related conditions.

Scope and Objectives

We began the audit in September 2009. Our audit addressed how productive are doctors providing psychiatric care; is the Division fully billing for psychiatric services when possible; and could the IT system better support the psychiatric care and billing processes. During the audit, we reviewed and discussed the agency's procedures with management and staff; analyzed doctor accountability data; observed and documented the billing process; and reviewed Division reports and operations documents. We interviewed managers at Renown Regional Medical Center, Saint Mary's Regional Medical Center, Sunrise Hospital and Medical Center, Palmetto GBA (federal Medicare intermediary), the Center for Medicare and Medicaid Services, U.S. Social Security Administration, Veterans Affairs Sierra Nevada Health Care System, and University of Nevada Medical School Associates. We also surveyed other states[2] to determine best practices. We concluded field work and testing in April 2010.

Our audit focused on the following objectives:

- ✓ Can the Division improve doctor efficiencies?
- ✓ Can the Division enhance billings?
- ✓ Should the Division evaluate its electronic medical records and billing system?

The Division of Internal Audits expresses appreciation to the Division's management and staff for their cooperation and assistance throughout the audit.

Contributors to this report included:

Warren Lowman
Executive Branch Auditor

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Executive Branch Auditor

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[2] Other states surveyed were Idaho, Iowa, Nebraska, New Mexico, Oklahoma, and Utah.

Division of Mental Health and Developmental Services Response and Implementation Plan

We provided draft copies of this report to Division officials for their review and comments. Their comments have been considered in the preparation of this report and are included in Appendix B. In its response, the Division accepted each of the recommendations we made. Appendix C includes a timetable to implement our recommendations.

NRS 353A.090 specifies that within six months after the Executive Branch Audit Committee releases the final audit report, the Chief of the Division of Internal Audits shall evaluate the steps the Division has taken to implement the recommendations and shall determine whether the steps are achieving the desired results. The Chief shall report the six-month follow-up results to the Committee and Division officials.

The following report contains our findings, conclusions, and recommendations.

Can the Division Improve Doctor Efficiencies?

The Division can improve doctor efficiencies by monitoring doctor attendance, monitoring outpatient doctor productivity, evaluating the productivity standard for outpatient doctors, and including productivity standards in doctor contracts. We estimate doctor inefficiencies cost the Division at least $2.5 million in fiscal year 2009.

The Division employs doctors to provide psychiatric services throughout Nevada. These services include psychiatric evaluations, medical prescriptions, and treatment services. These services are coordinated by the Northern and Southern Nevada Mental Health Services and Rural Services agencies. The Division is budgeted for approximately 66 full-time doctors in fiscal year 2010. The Division's psychiatric staff currently consists of 49 state employees and 31 contract doctors. The Division contracts with individual psychiatrists, doctors from the University of Nevada Reno (UNR), and doctors from temporary hire agencies to fill psychiatrist positions.

Doctors work in hospitals and outpatient clinics funded by the State:

- Doctors provide psychiatric services for clients who are admitted to the hospital (inpatient care) or who are in the hospital's patient observation unit (POU) to determine if they should be admitted for further treatment.

- Doctors work in outpatient clinics where clients come for routine and scheduled psychiatric services, such as checking on the effects of medication.

Exhibit I summarizes where doctors work in each of the Division's agencies providing mental health services.

Exhibit I

Doctor Work Locations

Northern Nevada Adult Mental Health Services (NNAMHS)	Southern Nevada Adult Mental Health Services (SNAMHS)	Rural Services (Rurals)
1 Inpatient hospital 1 Patient observation unit	1 Inpatient hospital 1 Patient observation unit	
2 Outpatient clinics	4 Outpatient clinics	19 Outpatient clinics

Doctors are expected to document client assessment, diagnosis, treatment, and response to treatment. For the purposes of this audit, we define these psychiatric services as productive services.

The Division seeks reimbursement for productive services by billing clients, Medicare, Medicaid, and private insurers. Doctors should account for their productive services to capture the full costs and enable billings because the federal government uses this data to determine what reimbursement the State will receive.

Our review shows reimbursements to the State for psychiatric services are directly related to how productive doctors are in treating patients and entering information in the Division's electronic medical records and billing system (system). We reviewed doctor productivity in hospitals and outpatient clinics to determine how efficient they are in treating patients and enabling the Division to bill for its services.

Hospital Doctor Productivity

The Division should monitor attendance to ensure hospital doctors are working a full day. This could benefit the State by up to $1.7 million annually.

The Division does not have a productivity standard for hospital doctors. Division officials state the productive services entered for hospital doctors in its system cannot be used to determine productivity. Additionally, the Division represents the hospital environment does not lend itself to productivity standards for doctors. Our survey of other states' mental health hospitals revealed they do not have doctor productivity standards either. The Division uses outcome measures, such as recidivism and length of stay to evaluate the productivity of its hospitals but not individual doctors.

Division officials state they are more concerned about doctors actually being in the hospital when they are scheduled to work. The Division's two hospitals have an electronic access control system that can monitor when an employee enters and leaves the facility.

We audited doctor attendance to determine if they were working full days. We sampled 22 percent of the Rawson-Neal Hospital's doctors during four months in fiscal year 2009 and concluded there may be an attendance problem at the hospital.[3] Our review shows hospital doctors are not, in general, working a full day. Exhibit II summarizes doctor attendance at the Rawson-Neal Hospital.

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[3] Our sample included 4 of approximately 18.53 full time doctor positions (22 percent) and the times recorded for their initial entry and departure from the Rawson-Neal Hospital during four months in fiscal year 2009 (November 2008, January, April, June 2009). Total hours were

Exhibit II

Rawson-Neal Hospital Attendance Summary

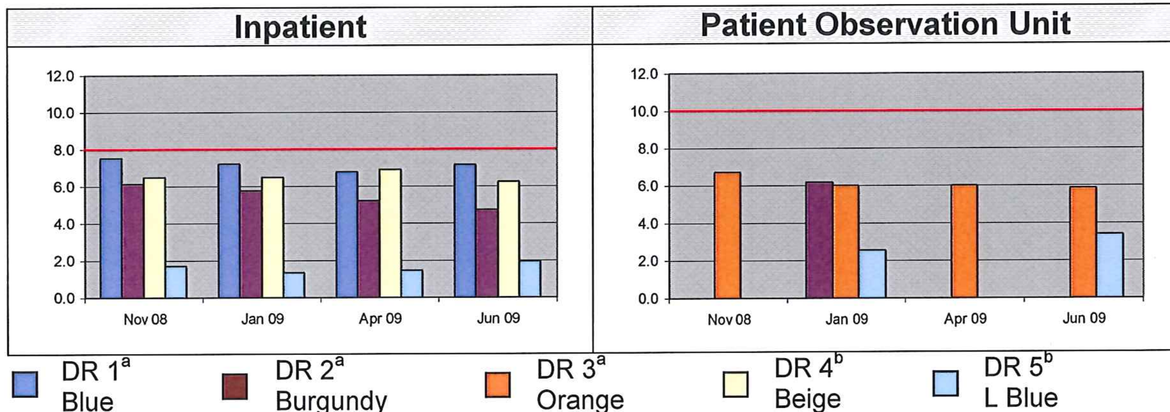

Table Notes:
[a] State employed doctors
[b] Contract doctors

The charts show, on average, none of the doctors we sampled were in the hospital for an 8-hour day in the inpatient units or a 10-hour day in the POU. All the doctors claimed a full day on their timesheets. We were able to identify one day in the four months when one of these doctors worked a full day. Doctor 5 averaged about 2 hours in the hospital on the days worked.

Supervisors should more closely monitor doctor attendance. If the supervisors have concerns about attendance, they can review the electronic access control system and doctor timesheets to determine if there is an attendance problem.

The Division represents that two previous attempts to hold doctors accountable for their attendance were met with resistance from doctors, including potential work stoppages or walkouts. Consequently, if the Division is unable to ensure proper doctor attendance, other alternatives should be considered, such as privatizing hospital doctors or payments to doctors based on the hours they are present.

We estimate the Division lost up to $1.7 million[4] from doctors' attendance problems at the Rawson-Neal Hospital in fiscal year 2009.

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adjusted for lunch breaks. We did not sample Dini-Townsend Hospital because of materiality; there are, in general, four doctors working the inpatient and patient observation units.

[4] The estimate is the value of the doctors' compensation for the time they were not in the hospital during their work day.

Recommendation

1. Monitor doctor attendance in hospitals.

Outpatient Doctor Productivity

The Division should monitor outpatient doctor productivity, evaluate productivity standards, and include a productivity standard in contracts. This will enable supervisors to evaluate doctor performance and ensure the Division is appropriately reimbursed for services it provides in the outpatient clinics.

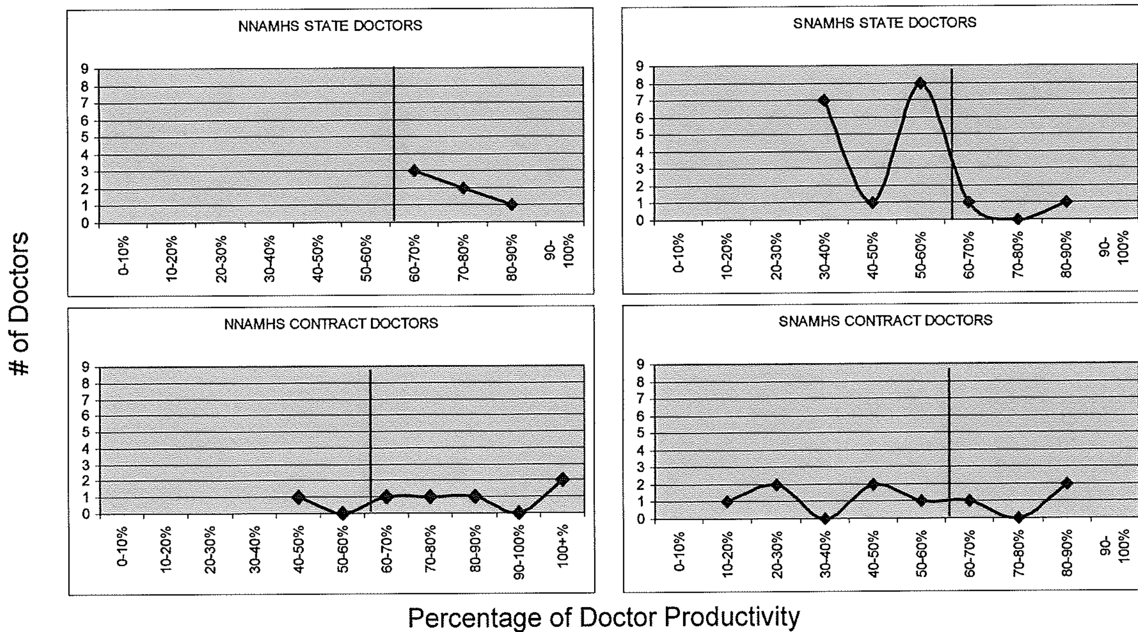
Productivity Affected by Data Entry and Attendance

The Division has a productivity standard for outpatient clinic doctors of 1,300 hours annually, or 62 percent of their total annual compensated hours. Moreover, the Division represents the 62 percent standard is the same for both a state employed and contract doctor.

Doctor productivity is calculated by comparing the amount of productive services they perform in relation to the time they work. Productive services include the time directly attributable to client care and documentation. We reviewed productive services and work hours for doctors working in outpatient clinics at NNAMHS and SNAMHS. Our review did not include productive services for doctors working in outpatient clinics in the Rurals as it consists of only 7.5 percent of outpatient doctor positions within the Division. Exhibit III summarizes outpatient doctor productivity rates.

Exhibit III

Outpatient Clinic Doctor Productivity



The results show the majority of NNAMHS doctors met or exceeded the productivity standard while the majority of SNAMHS doctors did not meet the Division's standard.

Our audit revealed that outpatient doctor productivity rates are affected, in general, by two elements: data entry and attendance.

- Data entry – Some doctors are not entering all the productive services they perform in the electronic system, according to Division staff. This system is used to record client treatment information and for billing purposes.

  Doctors are expected to enter treatment information in the client's record after each appointment. The Division maintains both an electronic and hard copy medical record. Some doctors may not be entering information into the electronic record for various reasons, such as time or difficulties with the system. Additionally, Division officials told us that doctor consultations with nurses for treatment opinions are not, in general, entered into the system. Consequently, the Division's electronic medical records system may not accurately reflect the current treatment and condition of the client. Doctors are also not entering information into the system for clients when they believe the Division will not receive reimbursement for treatment, although they may be entering this information in the hard copy medical record.

- Attendance – Some doctors may not be working a full day. Division staff represent that some outpatient doctors depart the clinics before the end of their work day. We were unable to verify attendance because the clinics do not have an electronic access control system to monitor staff.

Outpatient clinic managers are scheduling doctors' appointments to achieve 70 – 80 percent productivity; however, the Division does not monitor or reconcile doctor data entry of productive services. The Division's reconciliation process is limited to a medical review of clients' records.

Monitor Outpatient Doctor Productivity

The Division should establish policies and procedures to monitor outpatient doctor productivity and attendance. This will allow outpatient clinic managers to ensure doctors are entering all treatment information for billing purposes and working full days.

We recommend a two-step approach for monitoring doctor productivity that should be performed at least quarterly:

> **Step 1** – Monitor data entry of productive services through the electronic medical records and billing system and doctor timesheets.
>
> Our review of the Division's system shows its information can be used to calculate a productivity rate for outpatient doctors. Outpatient doctors are scheduled throughout the day for one patient at a time for appointments lasting, in general, 30 minutes. Doctors should be entering treatment information and documentation into the system after each appointment. As such, the system entries should closely reflect how productive the doctors are each day.
>
> The Division should calculate doctor productivity by comparing hours for productive services recorded in the system and hours recorded on doctor timesheets. This calculation can be accomplished with a spreadsheet. After calculating doctor productivity rates, the Division should evaluate the reasonableness of the doctor's productivity.
>
> If deemed unreasonable, Division officials should first address measures to improve data entry for treatment information and documentation, such as additional training. If Division officials determine data entry may not be the problem, they should move to the second step to monitor doctor attendance.
>
> **Step 2** – Monitor doctor attendance through an electronic access control system.

Supervisors should more closely monitor doctor attendance. If the supervisors have concerns about attendance, they should evaluate installing an electronic access control system. Some outpatient clinics have electronic key systems used for security but cannot provide summaries of individuals entering and exiting the facilities.

The State Department of Information Technology (DoIT) has an existing statewide contract to install and monitor electronic access control systems for State agencies. DoIT estimates it would cost approximately $72,500 to upgrade all outpatient clinics (including Rurals outpatient clinics) to be able to monitor doctor attendance.[5]

By monitoring productivity to ensure doctors achieve the 62 percent standard, the State will benefit by up to $672,000 annually in increased doctor productive time.[6] We were unable to determine the exact cause of the under productivity; it could be the result of data entry, absence from the workplace, or a combination of both.

Recommendation

2. Develop policies and procedures and implement a two-step process to monitor outpatient doctor productivity at least quarterly:
   Step 1 – Review doctor productivity by comparing timesheets and productive service hours; if productive services are recorded accurately and a productivity issue remains, move to step 2.
   Step 2 – Evaluate implementing an electronic access control system through DoIT.

Evaluate Productivity Standards

The Division should evaluate the 62 percent standard for outpatient doctor productivity. This would allow the Division to determine how its standard compares to current industry standards.

Another State entity, the University of Nevada Reno's Medical School Associates, operates outpatient clinics for medical care, such as internal medicine and pediatrics. Their standard for doctor productivity in the clinic is 80 percent. This productivity standard was established by the Medical Group

[5] The Department of Information Technology's cost estimate includes 2 control access panels for NNAMHS, 5 for SNAMHS, and 17 for Rurals outpatient clinics.
[6] The estimate is the value of the difference between the 62 percent productivity standard and the productivity rate of doctors that did not achieve the standard.

Management Association, an association for professional administrators and leaders of medical group practices.

The Division represents UNR's standard is not comparable to the outpatient clinics because the Division has a different type of clientele who are more likely to miss appointments, thereby lowering productivity.

The Division represents the outpatient doctor productivity standard has not been reviewed for over a decade. Evaluating doctor productivity against current industry standards will help the Division determine if it has appropriate expectations for its doctors.

Recommendation

3. Evaluate the Division's standard for outpatient doctor productivity.

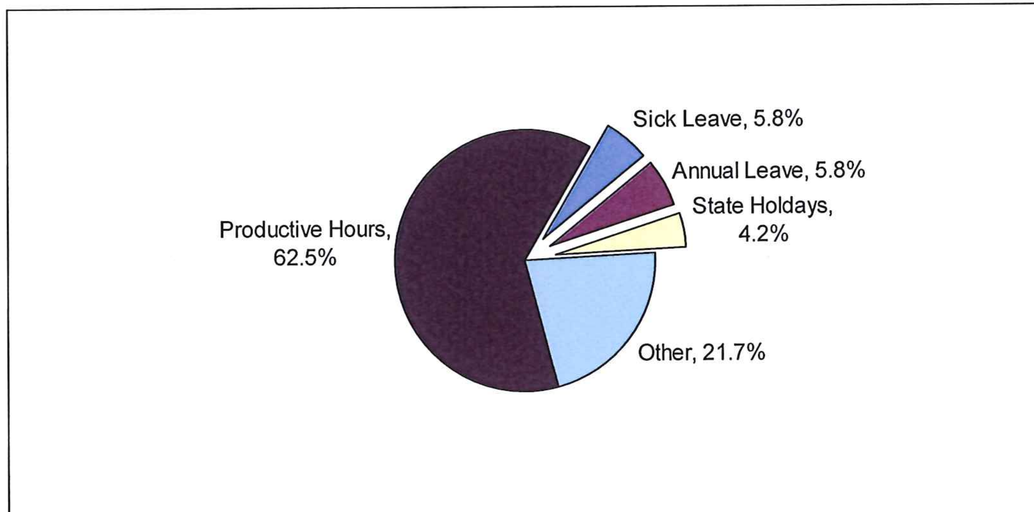
Evaluate and Include the Productivity Standard in Doctor Contracts

The Division should evaluate whether the productivity standard for a contract doctor and a State employed doctor should be the same.

The Division has a 62 percent productivity standard for State doctors. Exhibit IV (next page) summarizes the components of the Division's productivity standard for State doctors. The Division's standard is based on doctors being required to perform 1,300 annual productive hours. State doctors are paid for 2,080 hours annually, including sick leave, annual leave, and holidays. After removing sick leave, annual leave, and holidays, State doctors work 1,752 hours annually.

Exhibit IV

State Productivity Standard



Contract doctors fill in State doctor positions as needed. Generally, if a position is filled the entire year it would require 2,080 hours. Positions filled by contractors would not be paid for absences due to sick leave, annual leave, or holidays.

Contract doctors should have a higher productivity standard because they are not paid for non-productive hours (sick and annual leave, holidays, other). If contract doctors were required to perform comparable productive services, we estimate the productivity standard would be about 74 percent.[7] Contract doctors should exceed State doctors' productivity by about 12 percent. We estimate the Division could increase productive time for some outpatient contract doctors by over $122,000 if it adopted a higher standard.

In addition, our review shows there is no productivity standard included in doctor contracts. An established productivity standard in the contract would allow Division managers to better evaluate doctor performance.

Recommendations

4. Evaluate the productivity standard for contract doctors.

5. Include a productivity standard in doctor contracts.

[7] 1,300 productive hours divided by 1,752 State doctors hours at work.

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We estimate the Division could enhance efficiencies by at least $2.5 million annually by increased doctor productivity. See Exhibit V for a summary of estimated benefits for the State.

Exhibit V

Estimated Benefit

Recommendations	Amount
Enhanced inpatient attendance	$1,700,000
Enhanced outpatient doctor productivity	672,000
Increased contract doctor productivity standard	$122,000
Total Annual Benefit	**$2,494,000**

Can the Division Enhance Billings?

The Division can enhance billings by recording all hospital services, billing Medicare for doctor services, and obtaining pre-authorizations to bill for services. This could benefit the State by $500,000 annually.

Record Hospital Services

The Division should record all hospital productive services in the electronic medical records and billing system (system). This would allow the State to enhance reimbursements from clients, Medicare, Medicaid, and private insurers.

The Division's billing is completed electronically. Doctors are required to record their treatment information and documentation in the system. Staff other than the doctor record medical information in the system in some cases, according to Division officials.

Our review shows productive services are not being entered into the Division's system for all clients admitted to the hospitals. For example, in fiscal year 2009 the Division reported 3,885 clients were admitted in its hospitals. Each client admitted to the hospital should receive, in general, one psychiatric evaluation during their hospitalization. The evaluation must be completed by a doctor.

We reviewed productive services recorded by doctors during a four-month period in fiscal year 2009. Our review shows that doctors recorded just 20 percent of client psychiatric evaluations that should have been recorded. Consequently, the Division could not bill for the evaluations that are required for each client but were not recorded in the system for billing purposes. This amounted to approximately $130,000[8] in missing reimbursements.

Division officials represent that supervisors are not reviewing doctor entries into the system to ensure they are properly recording treatment information. This information is used to bill for productive services. Ensuring supervisors review doctor treatment entries will allow the Division to more fully bill for its services.

[8] The estimate is the projected reimbursement for clients with benefits.

Recommendation

6. Ensure all treatment information and documentation is entered into the Division's electronic medical records and billing system by requiring supervisory review.

Bill Medicare for Hospital Services

The Division can bill Medicare for qualified mental health professionals, including: psychiatrists, advanced nurse practitioners, psychologists, and licensed clinical social workers.[9] The psychiatric services provided by these professionals must be billed under individual Medicare enrollment numbers.

Mental health professionals must complete a 40-page application to receive a Medicare enrollment number. This process is termed credentialing. Not all Division mental health professionals have completed the credentialing process; as a result, neither of the Division's two hospitals have been fully billing for services provided to clients.

In 2009, the Division was not fully reimbursed from Medicare for hospital services because mental health professionals were not credentialed. The hospitals bill for Medicare Part A (room and board) but do not fully bill for Part B (doctor services).

- The Dini-Townsend hospital in Reno is billing for mental health professionals who are credentialed by Medicare, although not all professionals are credentialed.

- The Rawson-Neal hospital in Las Vegas has not billed Medicare for services because of a lack of credentialed professional staff. Division management represents doctors have started entering billing data into the billing system for later processing. Additionally, 4 psychiatrists have become credentialed.

We estimate the Division can enhance Medicare hospital billing by up to $280,000 by credentialing mental health professionals. See Exhibit VI.

[9] A qualified mental health professional is someone that the federal Center for Medicare and Medicaid Services has recognized for billing purposes and given that professional an enrollment number.

Exhibit VI

Medicare Part B Annual Billing

	NNAMHS[a]	SNAMHS[b]
Reimbursement	$63,000	$217,000

Table notes:

[a] We reviewed the four billing cycles for inpatient doctors' services that the Division has completed. We noted the amounts billed to Medicare and the total reimbursements received, then projected an annual increase for NNAMHS had all the doctors been appropriately credentialed.

[b] We estimated the potential reimbursement by projecting the NNAMHS results to SNAMHS.

Currently, NNAMHS provides the Medicare credentials application to new hires; however, some doctors still need to complete the application. SNAMHS is still working to complete credentialing.

Recommendations

7. Credential psychiatric staff in order to bill.

8. Bill Medicare for inpatient Part B.

Obtain Pre-authorization to Bill for Medicare Clients Who Have Exhausted Their Benefits

Medicare clients, in general, have a limited number of days for hospital services. Once clients have used all of their hospital days, they have exhausted their Medicare benefits. This is termed psych exhaust.

The psych exhaust status occurs after clients have used 190 days of hospital care. After this, Medicare will deny claims for reimbursement. However, once the Division receives the Medicare denial, it can bill Medicaid for co-eligible clients with a preauthorization. Co-eligible clients are those that have both Medicare and Medicaid benefits. The Division must obtain the pre-authorization for reimbursement from Medicaid prior to submitting the claim. We estimate the Division can enhance revenues from psych exhaust clients by up to $92,000 annually.[10]

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[10] The estimate is based on the projected number of psych exhaust Medicare clients who are also Medicaid eligible.

Recommendation

9. Obtain Medicaid preauthorization and bill psych exhaust Medicare clients.

*****

We estimate the Division could enhance revenues by $500,000 annually. See Exhibit VII for a summary of estimated benefits for the State.

Exhibit VII

Estimated Benefit

Recommendations	Amount
Record all billable services	$130,000
Bill Medicare for inpatient Part B services	280,000
Bill Medicaid for psych exhaust	92,000
Total Annual Reimbursement	**$502,000**

Should the Division Evaluate its Electronic Medical Records and Billing System?

The Division should plan and evaluate its electronic medical records and billing system (system) in order to increase staff productivity, allow for more complete billing, and more effectively manage the system. This could benefit the Division by up to 20 percent annually in system expenditures. Additionally, an enhanced system may free up to 10 percent in staff time.

The system is used primarily for medical records and billing:

- Medical records – Psychiatric professionals (psychiatrists, psychologists, licensed clinical social workers, nurses, and mental health technicians) use the system to record and manage client treatment. This includes writing client progress notes, documenting the treatment plan, listing doctors' orders, and scheduling appointments.
- Billing – The Division's central billing office[11] staff use the system to create the State's claims for reimbursement from clients, Medicare, Medicaid, and private insurers. The billing records include information on the psychiatric services provided to the client.

The Division has spent almost $6 million on the system since fiscal year 2004. Exhibit VIII summarizes the system costs.

Exhibit VIII

Electronic Medical Record and Billing System Costs

Description	Cost
Initial purchase & implementation [a]	$ 1,254,000
Annual ongoing costs to date [b]	3,540,000
Additional server purchases [c]	1,108,000
Total Cost of Purchase	**$ 5,902,000**

Table Notes:
[a] Fiscal Year 2004.
[b] Fiscal Years 2005 through 2010.
[c] Fiscal Years 2006 and 2007.

[11] The central billing office is located at the Division central office and is responsible for processing all claims for reimbursement for services from the Division's mental health agencies to clients, Medicare, Medicaid, and private insurers.

Division managers, doctors, and billing staff all represent the system has improved since it was first implemented; however, they pointed to many issues that remain. Staff represent they could be more productive, efficient, and accurate with a more user-friendly and capable system.

During our audit we consulted the Department of Information Technology (DoIT) who stated a need for planning by every State agency. Division staff represented the Division does not have a long term plan. The Division should ensure it is planning for its information technology (IT) requirements.

System Planning

The Division should establish a plan to address its system requirements. This could benefit the State by up to 20 percent of its annual system expenditures.

The Division has not analyzed its needs or reviewed other alternatives to its existing processes since the system was implemented in 2003. For example, the Division contracted to process Medicare claims without reviewing other products that would allow direct processing by its central billing office. Moreover, all of the system's capabilities are not fully implemented, including the on-line process for determining a client's eligibility for benefits and prescription interface with the pharmacy.

The Division incurred IT costs that a plan may have mitigated. In 2006, the Division purchased additional hardware to resolve the system's slow response time; however, it failed to purchase a corresponding database which was subsequently purchased months later. Had the Division planned thoroughly, it may have been able to save on a single purchase of the hardware and software at the same time.

The Division represents it does not have a current plan for IT acquisition, sustainment, or controls. Consequently, the Division cannot effectively budget for IT equipment and personnel.

The Division should develop an IT plan to more effectively budget for equipment and personnel. The IT Governance Institute[12] estimates that as much as 20 percent of IT expenditures may be wasteful without a plan. The Institute sets standards for an IT plan, including: defining requirements; identifying lifecycle costs and benefits; defining investment thresholds; and monitoring, optimizing, and reporting performance. See Appendix A for additional details on standards for a successful IT plan.

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[12] The IT Governance Institute (ITGI) is a nonprofit, vendor neutral organization that provides guidance and help to use information technologies to support organizational missions and goals. More information is available at: http://www.itgi.org

The Division recently hired a new IT manager and represents developing a plan is one of the manager's top priorities. We estimate the Division may be inefficiently spending up to 20 percent of its annual system expenditures without an IT plan.

Recommendation

10. Develop an IT plan in accordance with IT Governance Institute standards.

DoIT can assist the Division in the planning process. A Technical Information Request (TIR) can be the foundation for a good IT plan.

Technical Information Request (TIR)

The Division should work with DoIT to accomplish a TIR to review and assess its IT system. A TIR will help the Division develop its IT plan to improve or replace the existing system and efficiently spend limited resources.

A TIR is essentially a cost-benefit analysis for upgrading, replacing or continuing the current IT system used by an agency. It helps identify IT requirements and budgeting priorities to purchase and maintain the capabilities an agency needs to function efficiently. Additionally, IT projects costing more than $50,000 require a TIR, a threshold the Division is likely to top as it develops its IT plan.

System Issues

Our audit revealed several issues with the system that affect recording client treatment information and billing for productive services. These issues impact staff efficiency and point to the benefit of a TIR.

- The Division does not have the capability for electronic signatures, according to Division managers. Consequently, the Division must maintain some hard copy records to comply with federal guidelines.

- The software is not user friendly; therefore, some staff do not enter information fully or correctly into the system. Consequently, the Division cannot fully bill for its services.

- The system allows improper information to be entered that can cause disruptions. For example, in 2009 and 2010 a user disrupted the system by improperly entering data that interrupted the billing process for several days to weeks. This required additional vendor support to remedy.

- We noted several system limitations related to billing and management. These limitations did not allow managers to generate reports and information to help them monitor treatment and billing processes. For example:
  - Central Billing Office was unable to use the system to track patient reimbursements from Medicare and Medicaid; such abilities would allow management to monitor the effectiveness of the billing process.
  - Central Billing Office was unable to track information on psych exhaust clients; such abilities would allow management to refine the current practice of billing all psych exhaust claims and to measure the impact of that billing effort.
  - Outpatient doctor availability and appointments could not be reconciled except by hand; such abilities would reduce staff workloads and enable better management.

The Division's experience with its system is not unique. We surveyed three other states that use the system; two are not satisfied with the system's performance. The third state had just implemented the system.

The Division may gain efficiencies by improving its electronic medical records and billing system. A TIR will help evaluate these efficiencies. We estimate the Division could free up to ten percent of staff time annually from improving the capabilities of its system.[13]

Recommendation

11. Complete a Technical Investment Request that considers both modifying and replacing the current electronic medical records and billing system.

[13] This estimate is based on Division managers' projections of time savings for selected staff (psychiatrists, psychologist, nurses, licensed clinical social workers, and social workers that use the system).

Appendix A

IT Governance Institute Standards for an IT Plan

According to the IT Governance Institute[14], key management practices include:

1. Ensure informed and committed leadership.
2. Define and implement processes.
3. Define roles and responsibilities.
4. Ensure appropriate and accepted accountability.
5. Define information requirements.
6. Establish reporting requirements.
7. Establish organizational structures.
8. Establish strategic direction.
9. Define investment categories.
10. Determine a target portfolio (system components) mix.
11. Define evaluation criteria by category.
12. Maintain a human resource inventory.
13. Identify resource requirements.
14. Perform a gap analysis.
15. Develop a resourcing plan.
16. Monitor resource requirements and utilization.
17. Establish an investment threshold.
18. Evaluate the initial program concept business case.
19. Evaluate and assign a relative score to the program business case.
20. Create an overall portfolio view.
21. Make and communicate the investment decision.
22. Stage-gate (and fund) selected programs.
23. Optimize portfolio performance.
24. Re-prioritize the portfolio.
25. Monitor and report on portfolio performance.
26. Develop a high-level definition of investment opportunity.
27. Develop an initial program concept business case.
28. Develop a clear understanding of candidate programs.
29. Perform alternatives analysis.
30. Develop a program plan.
31. Develop a benefits realization plan.
32. Identify full life cycle costs and benefits.
33. Develop a detailed program business case.
34. Assign clear accountability and ownership.
35. Initiate, plan and launch the program.
36. Manage the program.

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[14] Information obtained through DoIT and available on http://www.itgi.org/

37. Manage/track benefits.
38. Update the business case.
39. Monitor and report on program performance.
40. Retire the program.

Appendix B

Division of Mental Health and Developmental Services Response and Implementation Plan

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES
4126 Technology Way, Suite 201
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JIM GIBBONS
Governor
MICHAEL J. WILLDEN
Director

HAROLD COOK, Ph.D.
Administrator
DEE McLELLAN
Deputy Administrator

MEMORANDUM

June 15, 2010

Mr. William Chisel, Chief
Division of Internal Audits
3427 Old Hot Springs Road, Suite 103
Carson City, NV 89706

RE: Response to Agency Audit September, 2009

Dear Mr. Chisel:

Response and Implementation plan for the Internal Audit

Recommendations

1. Monitor physicians in hospitals: The Division accepts this recommendation but will also review alternative solutions including:
   - Privatizing medical services
   - Negotiating reduced FTE for physicians who are not currently working their designated FTE hours
   - Re-evaluating caseload ratios of inpatient physicians and reducing staffing levels or develop procedures for physicians
   - To work multiple duty stations

   Implementation time—6 months

2. Review Physician Productivity: Although the Division has some concerns with these data the Division accepts this recommendation. The division notes that the internal audit staff had considerable difficulty over a lengthy period of time producing the data in this report and it is still not clear how accurate the data are. Producing these data was a time intensive and complicated process. Also, Division has been working to improve productivity since these data were collected (calendar years 2008 and 2009) and we anticipate that SNAMHS physician productivity is currently at or near Division standard.
   Implementation time—6 months

3, 4, 5 Evaluate productivity standard for contract physicians: The Division accepts this recommendation. A new standard will be developed and incorporated into new and re-newal contracts.
Implementation Time: 6 months to develop new standard and 1.5 years to incorporate standard into all contracts.

6. Ensure treatment information is entered into the electronic medical record by requiring supervisory review: The Division accepts this recommendation. Medical records are already the subject of peer review and utilization review. These review processes include reports to supervisors. These reviews, however, focus on the medical standards of the record not billing or electronic medical record issues. Both review procedures will be expanded to include a review of these issues.

Implementation time: 6 months

7, 8: Credential Medical staff and bill Medicare Part B: The Division accepts this recommendation. The Division has been improving this billing procedure and has successfully credentialed 7 physicians in the past 6 months. The Division is, however, not confidant that the anticipated revenue increase will be as great as internal audit staff estimate. Division hospitals have seen a decline in Medicare bed days over the past 18 months as private providers have been more accepting of Medicare patients. As a result of health care reform and other Federal legislation, Medicare rates will almost certainly increase in the future which will make Medicare patients that much more attractive to the private sector thus further diminishing the Division's ability to realize this increase.

Implementation time—6 months

9. Bill Medicaid for Patients who have exhausted Medicare benefits: The Division accepts this recommendation and has been attempting to implement this procedure for the past 6 months. There are a number of complexities involving multiple electronic record systems that make this a difficult procedure to implement. The internal audit analysis does not include an estimate of the cost of staff time required for this procedure but it is the case that billing staff need to spend considerable time coordinating these benefits. This staff time will reduce the fiscal benefit estimated in this report. It should also be noted that only those very limited number of dual eligible patients outside the ages of 21 and 65 are eligible for Medicaid inpatient psychiatric services.

Implementation time: 6 months

10. Develop an IT plan: The Division accepts this recommendation. The Division intends to develop an IT plan. This plan will be consistent with developing health information exchange and health information technology standards. This plan will also be consistent with the Division's FY2012/2013 budget.

Implementation time: 1 year

11. Complete a Technical Investment Request that considers both modifying and replacing the existing system: The Division accepts this recommendation and will develop a TIR for the FY2014/2015 biennium. Division does note that Federal reviewers conducting a Mental Health Block Grant review in June, 2010 made positive comments abut the AVATAR system including; significant system improvement in the past two years and that there are efficiencies created by the systems medical data storage and reporting capabilities. These observations will be included in the final review report. While the Division does not dispute that the system can be improved, there is a broader context in which it can be argued that there are many positive aspects to the system which mitigate some of the inefficiencies noted by internal audit staff.

Implementation Time: 3 years

Sincerely,

Harold Cook, Ph. D.
Administrator

CC: Michael J. Willden, Director, DHHS
Dee McLellan, Deputy Administrator
Dave Prather, ASO IV, MHDS
Robin Hager, Budget Analyst

Appendix C

Timetable for Implementing Audit Recommendations

In consultation with the Division, the Division of Internal Audits categorized the 11 recommendations contained in this report into an implementation time frame of more than six months. The Division should begin taking steps to implement all recommendations as soon as possible. The Division's target completion dates are incorporated from Appendix B.

Recommendations	Time Frame
1. Monitor doctor attendance in hospitals. (page 9)	Dec 2010
2. Develop policies and procedures and implement a two-step process to monitor outpatient doctor productivity at least quarterly. Step 1 – Review doctor productivity by comparing timesheets and productive service hours; if productive services are recorded accurately and a productivity issue remains, move to step 2. Step 2 – Evaluate implementing an electronic access control system through DoIT. (page 12)	Dec 2010
3. Evaluate the Division's standard for outpatient doctor productivity. (page 13)	Dec 2010
4. Evaluate the productivity standard for contract doctors. (page 14)	Dec 2010
5. Include a productivity standard in doctor contracts. (page 14)	Dec 2011
6. Ensure all treatment information and documentation is entered into the Division's electronic medical records and billing system by requiring supervisory review. (page 17)	Dec 2010
7. Credential psychiatric staff in order to bill. (page 18)	Dec 2010
8. Bill Medicare for inpatient Part B. (page 18)	Dec 2010

9. Obtain Medicaid preauthorization and bill psych exhaust Medicare clients. (page 19) — Dec 2010

10. Develop and IT plan in accordance with IT Governance Institute standards. (page 22) — Jun 2011

11. Complete a Technical Investment Request that considers both modifying and replacing the current electronic medical records and billing system. (page 23) — Jun 2013

The Division of Internal Audits shall evaluate the action taken by the Division concerning report recommendations within six months from the issuance of this report. The Division of Internal Audits must report the results of its evaluation to the Committee and the Division.