Memorial Healthcare System

MEMORIAL REGIONAL HOSPITAL ● MEMORIAL REGIONAL HOSPITAL SOUTH ● JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST ● MEMORIAL HOSPITAL MIRAMAR ● MEMORIAL HOSPITAL PEMBROKE

DATE: July 31, 2023

TO: K. Scott Wester, President and Chief Executive Officer, MHS

SUBJECT: **AUDIT AND COMPLIANCE – FIRST QUARTERLY REPORT FISCAL YEAR 2024**

Attached is a copy of the first quarterly report of fiscal year 2024 summarizing the activities of the Internal Audit and Compliance Department from May 1, 2023, through July 31, 2023, for your records.

Please let me know if you have any questions regarding this report.

Denise (Denny) DiCesare
Chief Compliance and Internal Audit Officer

cc: Leah Carpenter, Executive Vice President and Chief Operations Officer, MHS
Matt Muhart, Executive Vice President and Chief Strategy Officer, MHS
Dave Smith, Executive Vice President and Chief Financial Officer, MHS
Frank Rainer, Senior Vice President and General Counsel, SBHD

I. WRITTEN STANDARDS AND PROCEDURES

The following policies and procedures were reviewed and/or revised during the quarter:

Reviewed:

- Health Information Management.

Revised:

- Disability.

II. COMPLIANCE OFFICER

The compliance officer attended the following meetings during the quarter:

- Florida Compliance and Privacy Consortium: One Session;
- Chief Compliance Officer's Roundtable: One Session; and
- RSM Annual Government and Health Care Seminar: One Session.

III. TRAINING AND EDUCATION

The following compliance training was provided during the quarter:

- New Employee Orientation: Thirteen Sessions
- Leadership Essentials: Two Sessions
- Compliance Working Committee: One Session

IV. MONITORING & AUDITING

V. RESPONSE & PREVENTION

A. Internal Audit

Assistance Provided to RSM for Memorial Healthcare System's FY 2023 Audit

Background

As part of the annual financial audit, we provided audit assistance as directed by RSM US LLP (RSM), our external auditors.

We performed walkthrough testing of key business processes including payroll; prepaid expenses; capital assets and plant, property and equipment (PPE); inventory; pension; and cash disbursements. We also performed substantive testing of samples of payroll; fixed assets and construction in progress (CIP) additions; patient revenue; accounts receivable hindsight; credit balances; zero balance patient account testing; unapplied discounts testing; and patient payment history testing for the Florida Medicaid Waiver revenue recognized in fiscal year (FY) 2023.

The purpose of this internal audit report was to summarize the results of the audit assistance provided.

Observations

There were no exceptions noted or recommendations made.

Recommendations

None.

Internal Audit of the Retirement Plan for Employees of South Broward Hospital District

Background

The Retirement Plan for Employees of South Broward Hospital District (SBHD) was established on May 1, 1969. The plan has been amended several times and most recently amended and restated effective May 1, 2015. Full-time new hires after November 1, 2011, are no longer eligible to participate in the defined benefit plan. Instead, they are offered participation in a 401(a) defined contribution plan. Effective January 3, 2017, Memorial Healthcare System (MHS) contracted with Transamerica Retirement Solutions, LLC (TRS) to provide administrative, benefit disbursements and trust and custody services for the Retirement Plan. With this background, the purpose of this audit was to determine if the terms of the contract between MHS and TRS are operating as agreed and that pension benefits were paid to eligible beneficiaries with proper documentation. Using a random sample of 30 pension payments from the Human Resources (HR) Masterfile of pensioners' accounts, we verified those selections to Pension Calculation Worksheets and to the TRS payment reconciliations performed by Corporate Finance. To test the accuracy of the pension administration services provided by TRS, we obtained the New Retiree and Death Notice reports from TRS for November 2022 and performed additional audit procedures. We traced payments made to all 21 individuals appearing on the New Retiree Report to the TRS payment reconciliation, agreed three of those payments to the Retirement Benefit Application forms and Pension Calculation Worksheets and ensured that individuals opting for lump sum payments did not receive recurring payments in subsequent months. We verified that pension payments to retirees on the Death Notice Report for November 2022 were appropriately discontinued or switched to any named survivors and that the death status was accurately reflected in the HR Masterfile. Finally, we reviewed the pension payment reconciliation process performed by Corporate Finance in consultation with HR and compared the monthly TRS direct payout disbursements from the payment reconciliations to the Pension Funding and Disbursement reports for fiscal year (FY) 2023 maintained by MHS Treasury.

Observations

All 30 selections from the HR Masterfile were supported by Pension Calculation Worksheets which agreed to the amounts disbursed by TRS. There were no exceptions noted for the new retirees who had pension benefits initiated in November 2022; all were covered employees and therefore eligible for pension payments. Individuals electing to receive lump sum payments were paid only once and supporting documents reviewed for the three payments selected from the New Retiree Report for November 2022 appropriately supported the amounts and frequency of payments. We confirmed that pension payments to retirees on the Death Report were appropriately discontinued in subsequent months and the death status for those retirees were updated on the HR Masterfile. The payment reconciliations for FY 2023 were performed timely and evidence of explanations from HR were reviewed for reconciling items; all were appropriate. The Pension Funding and Disbursement reports all agreed to the monthly TRS direct payout reports for FY 2023 and the employer contributions from the funding summaries corresponded to RSM's audited financial statements for FY 2023.

Recommendations

None.

South Broward Hospital District Construction Projects

Twenty-seven payment vouchers for 11 construction projects were audited during the quarter, as shown on Exhibit A. No irregularities were found during these audits.

South Broward Hospital District Requests for Proposal and Competitive Quotes

Thirteen Requests for Proposal and 30 Competitive Quotes were audited during the quarter, as shown on Exhibit B. No irregularities were found during these audits.

Board Expenses

Board Expenses were audited during the quarter. The list of expenses audited for the quarter will be presented and discussed during the meeting.

B. Compliance

Compliance Audit of the 340B Program at Memorial Healthcare System - FY 2024 First Quarter

Background

The 340B Program is administered and overseen by the Health Resources and Services Administration (HRSA). The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible healthcare organizations/covered entities at significantly reduced prices. To participate, eligible organizations must register and be enrolled with the 340B Program and maintain an up-to-date 340B database, recertify eligibility yearly, and prevent duplicate discounts by having mechanisms in place to prevent receiving a 340B price and a Medicaid drug rebate for the same drug. Any covered entity that fails to comply with the program requirements may be liable to manufacturers for refunds of the discounts obtained. To be eligible for the 340B program, patients must have an eligible medication order or prescription, and receive health care services other than drugs from the covered entity, such as treatment in a hospital-based mixed-use area, a location serving patient type of both inpatient and outpatient, and classified as an outpatient in the electronic health record (EHR) at the time of medication administration.

Memorial Healthcare System (MHS) participates in the 340B Program for Memorial Regional Hospital (MRH) which includes Memorial Regional Hospital South (MRHS) and Joe DiMaggio Children's Hospital (JDCH); Memorial Hospital Pembroke (MHP); Memorial Hospital West (MHW); and Memorial Hospital Miramar (MHM). In order to manage the 340B Program, MHS uses split-billing software from Verity Solutions Group (Verity) to determine what each pharmacy needs to purchase at the 340B price. Replenishment is accumulated each time a drug is administered as outpatient and meets all the program requirements. The previous audit had findings related to the Automated Dispensing Cabinet (ADC), our medication dispensing system, overrides and eligibility of medication orders, subsequently this parameter was included in the 340B audits.

Observations

Of the 300 pharmacy claims reviewed, there were three claims with ADC overrides for which we were unable to find the original provider order in Epic, our EHR . An ADC override occurs when a clinician pulls medication from the ADC without the pharmacy verifying the order or during emergent situations when the provider may give a verbal order and medication is taken out as an override. As per the MHS Medication Overrides Policy, each override should be reconciled to an original order. According to 340B management, a technical issue in Epic resulted in the specific medications being removed from the medication order list, which prevented the clinician from

placing the order in Epic. Subsequently, the three orders from February to March 2023 were obtained from the provider in July and entered as a late entry four to five months after the date of administration. As per The Centers for Medicare and Medicaid (CMS) policy, late entries must be made as close as possible to the date/time of service. Reasonable time frame for delayed entries is within 24 to 48 hours after the service. Based on this finding, we reviewed 100% of the overrides for one medication, Albumin/Flexbumin, during the same time period and identified three more claims missing the original order in Epic.

Recommendations

We recommended 340B management review the claims missing the original order in Epic, and reverse the 340B claims and charges, as appropriate to regulations and guidelines. We recommended 340B management review all ADC overrides retrospectively to a year to identify patients who did not meet the 340B eligibility because of missing the original order and reverse the claims, if necessary. We recommended pharmacy management review the policies and update to reflect the CMS policy on timeliness of orders. We recommended pharmacy management work with the Epic Team to develop a system/process to ensure medication overrides have linked provider orders entered in a timely manner in Epic. We recommended pharmacy management review the existing process for reconciling ADC overrides to an original order and develop a standardized process. We recommended pharmacy management work with nursing management in reeducating nurses on the medication overrides policy to ensure provider orders are obtained and documented in Epic, in a timely manner.

Dorinda Segovia, Vice President, Pharmacy Services, MHS and Scott Davis, Vice President, Reimbursement and Revenue Integrity, MHS agreed with the findings and recommendations and have provided an action plan.

Compliance Audit of Documentation and Billing of the Diabetes Self-Management Education and Support Services Program in the Diabetes and Nutrition Center at Memorial Regional Hospital

Background

Diabetes self-management training (DSMT) is a full range of educational and training services offered to people diagnosed with diabetes for the successful self-management of the chronic disease and related conditions.

Medicare covers DSMT services furnished by an accredited entity who meets certain quality standards. There is a one-time benefit of initial 10 hours of training and a yearly follow-up of two hours of training. Nine of the 10 hours must be furnished in a group setting of two to 20 individuals. One hour of individual DSMT is used to evaluate training needs. Individualized initial DSMT is covered only if there are no group sessions available within two months of the date the DSMT is ordered or the need for individual training is documented by the referring provider on the order/referral and in the medical record. The initial and follow-up training must be furnished in increments of 30 minutes which is equal to one unit. Rounding of time is not allowed and hours must be completed within the required time to be reimbursed. The order/referral must include the number of initial hours ordered; the topics to be covered; and a determination that the patient should receive individual or group training. The treating provider managing the patient's diabetic condition certifies that such services are needed and maintains a comprehensive plan of care, which must also be incorporated into the DSMT provider's medical records. For the follow-up training, the provider treating the beneficiary must document on the referral and in the medical record that the beneficiary has been diagnosed with diabetes and the

training to be addressed. The DSMT service provider must maintain documentation of the original order from the physician and any special conditions noted by the physician. All DSMT programs must be accredited by Centers for Medicare and Medicaid Services (CMS) as meeting certain quality standards. Currently the Diabetes Self-Management Education and Support (DSMES) program is recognized by the American diabetes Association (ADA) to provide outpatient DSMT services.

Observations

All 30 patient accounts with 85 dates of service had a provider order/referral to the DSMES. Two of the 30 accounts had orders/referrals with all the Medicare required components and twenty-eight did not. Those accounts used the DSMES orders/referrals templates in Epic electronic health record that did not include all the requirements and non-Memorial Healthcare System (MHS) providers who did not write all components required by Medicare. Eighty-four of 85 dates of service had documentation verifying the education or training provided, including plans and goals. In one of 85 dates of service, documentation indicated education was not provided. Seventy-seven of 85 dates of service had the start and stop time documented on the educator's note and encounter visit summary note used for charging. Eight dates of service had the start and stop time documented in the encounter visit summary but not on the educator's note. In 33 dates of service, time was not documented in 30-minute increments as required.

Eighty-four of 85 dates of service were coded accurately according to documentation of training provided. One account with an appropriate order had four dates of service that met all Medicare documentation requirements for the visit. Two of those dates of service were reimbursed higher due to rounding up time when charging. The other account with an appropriate order had two dates of service that met Medicare requirements and were reimbursed appropriately. In one date of service, documentation indicated education or training was not provided but was coded and charged. Of the 85 dates of service, 75 were reimbursed, although documentation indicated Medicare requirements were not met for orders/referrals and documentation of the time components. Four dates of service were appropriately denied as service provided did not meet Medicare follow-up training requirements.

Recommendations

We recommended the DSMES program management reeducate staff on documenting and charging time. We recommended the DSMES program management collaborate with Information Technology to review and update the current order/referral template in Epic to include all Medicare's required components. We recommended the DSMES program management develop a process to ensure all orders from providers include all Medicare required components, that the patient has a diagnosis of diabetes, and the required documentation are received from the ordering provider. We recommended the DSMES program management review and comply with the Medicare requirements for providing and billing DSMT. We recommended Accounts Receivable Management (ARM) rebill the two identified dates of service with inaccurate units and refund the identified dates of service that did not meet Medicare requirements. We recommended the DSMES program management review all Medicare and Medicare Advantage accounts billed for DSMT retrospectively to determine compliance with Medicare requirements. If errors are noted, the DSMES management collaborate with ARM to correct, refund or rebill accounts identified with errors.

Peter Powers, Administrator and Chief Executive Officer, MRH, and Walter Bussell Chief

Financial Officer, MRH, agreed with the findings and recommendations of this audit and have provided an action plan.

Compliance Audit of Documentation and Billing for assessment of antibody to Human Leukocyte Antigen Class I with high-definition qualitative panel at Memorial Regional Hospital

Background

In transplantation medicine, Human Leukocyte Antigen (HLA) antibody testing is utilized in predicting the likelihood of organ rejection among pre-transplant recipients and for monitoring the recipient's risk to develop organ rejection or response to treatment among post-transplant recipients. The Centers for Medicare and Medicaid Services (CMS) recognizes that specimens drawn or collected by one laboratory are sometimes referred to another laboratory for testing. The Memorial Healthcare System (MHS) Memorial Transplant Institute (MTI) and the Immunology and Histocompatibility Laboratory/University of Miami (UM) Department of Surgery have an existing agreement wherein MHS refers the laboratory (lab) specimens to UM for the processing and interpretation of histocompatibility lab tests. UM provides an itemized invoice to MHS each month of the referred lab tests from the preceding month. MHS pays UM within 45 days of receiving the invoice and bills Medicare for the referred lab tests.

MHS Compliance and Internal Audit Department received a Comparative Billing Report (CBR), an educational letter from First Coast Service Options, Inc. (FCSO), our Medicare Administrative Contractor (MAC), indicating that their recent data analyses identified that an aberrancy existed at Memorial Regional Hospital (MRH) for Current Procedural Terminology (CPT) code 86832. CPT code 86832 is the procedural code for assessment of antibody to HLA Class I with high-definition qualitative panel for identification of antibody specificities. In response to this notice, the Compliance and Internal Audit Department performed an audit of the MTI Adult Kidney Transplant Center for CPT code 86832. The purpose of this audit was to determine if documentation supports medical necessity for assessment of antibody to HLA Class I with high-definition qualitative panel (CPT code 86832) and the accuracy of charging, coding, and billing at MRH.

Observations

We reviewed a total of 30 Medicare patients with 209 dates of service. We noted that all 30 patients had kidney transplant performed at MRH. All 30 patients had provider orders for HLA antibody testing Class I and II, and documentation supporting medical necessity, and justification for order frequency. One service date was missing the result. Subsequently, the report of the lab result was obtained from UM and scanned in Epic, our electronic health records (EHRs). We verified that the laboratory charges are different for pre- and post-kidney transplant patients as set by UM and in accordance with the Organ Transplantation MAC and CMS guidelines for lab fee schedule. Of the 209 dates of service, 25 were billed pre-transplant charges for HLA antibody testing Class I and II by MHS to Medicare. Of the 25 billed with pre-transplant charges, three service dates were paid appropriately because the patients were also re-evaluated to receive another kidney transplant. The other 22 service dates should have been billed the post-transplant charges. Of the 22 service dates that should have been billed post-transplant charges, we noted 13 were reimbursed by Medicare according to the pre-transplant amount, resulting in an underpayment of approximately $2,583.75 while nine were included in other services and were not separately reimbursable. We also noted that the invoices from UM to MHS for the 22 service dates were corrected by UM and reflected the appropriate post-transplant charges. Subsequently, updates were made to the

laboratory order to distinguish the pre- and post- HLA antibody laboratory orders.

Recommendations

We recommended MTI management perform routine audits of the laboratory orders of HLA testing to ensure accuracy and appropriateness. We recommended MTI management work with Information Technology (IT) to develop a process/system to review the HLA orders for accuracy and required components prior to being sent to the reference laboratory. We recommended MTI management work with IT to develop a process on reconciling histocompatibility lab results to ensure appropriateness of UM invoicing and Medicare billing.

Peter Powers, Administrator and Chief Executive Officer, MRH and Walter Bussell, Chief Financial Officer, MRH agreed with the findings and recommendations of this audit and have provided an action plan.

Compliance Audit of the Medicare Outpatient Observation Notice (MOON) at Memorial Hospital Miramar

Background

The Centers for Medicare & Medicaid Services (CMS) Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals and Critical Access Hospitals (CAH) to provide written and verbal notice to patients receiving observation services as outpatients for more than 24 hours. The Medicare Outpatient Observation Notice (MOON) informs Medicare and Medicare Advantage beneficiaries when they are outpatient receiving observation services and not inpatient of the hospital or CAH and the reason for such status. The hospital or CAH can provide the MOON at any time after observation services begin but no later than 36 hours. The start time of observation services begins when physician's order is documented in the patient's medical record. Hospitals must complete the Office of Management and Budget (OMB) approved MOON form with the patient's name; patient number; and reason patient is an outpatient.

The standardized written MOON and verbal explanation must be provided to the beneficiary or the patient's representative. If the beneficiary is temporarily incapacitated, a family member or close friend may be a representative for the purpose of receiving the MOON. When the individual receiving the notice is unable to read the written contents and/or comprehend the required verbal explanation, hospitals and CAHs must employ their usual procedures to ensure notice comprehension. The hospital or CAH must ensure that the beneficiary or representative signs and dates the MOON to demonstrate that the beneficiary or representative received and understood the notice and the beneficiary must be given a paper copy of the MOON at the time of delivery. If the beneficiary refuses to sign the MOON, and there is no representative to sign on behalf of the beneficiary, the staff member who presented the written notification must annotate in the "Additional Information" section to certify that the notification was presented, the date and time the notification was presented, and then sign with their name and title. The date and time of refusal is considered the date of notice receipt. If a representative is not physically present, the MOON must be delivered telephonically. The staff member who initiated contact must annotate in the "Additional Information" section the name of the representative contacted, date, time and the telephone number called. The date and time the hospital or CAH communicates or make a good faith attempt to communicate is considered the receipt date. A hard copy of the annotated MOON must be mailed to the representative the day telephone contact is made. The hospital or CAH must retain the original signed MOON in the beneficiary's medical record. Failure to provide the MOON to applicable beneficiaries is considered a violation of the hospital's Medicare provider

agreement and could result in termination of the hospital's Medicare provider agreement.

The Patient Financial Services Department (PFS) staff at Memorial Hospital Miramar (MHM) provides the MOON to beneficiaries after physician's order for observation service is documented on the medical record and the account is updated by admitting department to reflect the status. However, the Clinical Effectiveness Department ensures the MOON is delivered to all Medicare and Medicare Advantage beneficiaries.

Observations

All 30 accounts reviewed had observation orders with start time of service entered by the provider. In twenty-six accounts the OMB approved MOON forms were used, four of which had expired MOON forms in the medical record. There were four accounts that did not have a MOON in the medical records. Of the twenty-six accounts that had a MOON in the medical record, thirteen had documentation that the MOONs were discussed with the patient or representative telephonically but did not have the "additional information" section annotated or documentation that the hard copy was mailed to the representative in the medical records as required. Five accounts had a MOON delivered to the patient or representative but were missing the date and time of the patient's or representative's signature and the relationship to other signatures were not identified. The remaining eight accounts had all Medicare required documentation and were delivered within the set guidelines.

Recommendations

We recommended that the Clinical Effectiveness management reeducate the staff regarding the requirements for compliance with providing the MOON according to the CMS NOTICE Act regulation. We recommended the Patient Financial Services Team in the Emergency Department continue to help in providing the MOON to patients when there is sufficient time prior to transfer to the floor. We recommended the Clinical Effectiveness management review current process for completing MOONs and update as necessary to ensure compliance with Medicare requirements. We recommended the Clinical Effectiveness management perform regular prospective reviews on Medicare observation accounts to ensure compliance with the completion of Medicare requirements.

Stephen Demers, Chief Executive Officer, MHM and Veronica Bautista, Chief Financial Officer, MHM agreed with the findings and recommendations of this audit and have provided an action plan.

Compliance Audit of the Important Message from Medicare (IM) at Memorial Hospital Pembroke

Background

In January 2022, the Centers for Medicare & Medicaid Services (CMS) revised the Medicare Claims Processing Manual on the Expedited Determinations of Inpatient Hospital Discharges. Hospitals and Critical Access Hospitals (CAHs) must deliver a written notice, the Important Message (IM) from Medicare to all Medicare and Medicare Advantage (MA) beneficiaries who are receiving inpatient hospital services, to inform them that they have a statutory right to appeal to a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for an expedited review when a hospital, with physician concurrence, determines that inpatient care is no longer necessary. The first IM must be delivered within two calendar days of the admission date or no more than seven days before the admission date if the patient is seen for a preadmission

visit. A follow-up IM must be delivered within two days of the planned date of discharge and no later than four hours prior to discharge. If the first IM is within two calendar days of the date of discharge, no follow-up notice is required.

The standardized written IM and verbal explanation must be provided to the beneficiary or the representative. If the beneficiary is incapacitated, a family member or close friend may receive the IM. When the individual receiving the notice is unable to read the written contents and/or comprehend the verbal explanation, usual procedures are employed to ensure notice comprehension. The beneficiary or representative must sign and date the IM. Beneficiaries still remain entitled to an expedited determination if the beneficiary or representative refuses to sign the IM. The staff member who presented the IM must annotate the notice with the date of refusal. The IM must be delivered telephonically to a representative who is not physically present, and the "additional information" section must be annotated with the staff member's name who initiated the contact, the representative's name, date, time, and telephone number. A hard copy of the IM must be mailed to the representative on the day telephone contact is made. Failure to provide the IM to applicable beneficiaries is considered a violation and could result in termination of the hospital's Medicare provider agreement. At Memorial Hospital Pembroke (MHP), the Patient Financial Services (PFS) Department staff provides the first IM and Clinical Effectiveness (CE) Department provides the follow-up IM to beneficiaries.

Observations

All 30 accounts reviewed had inpatient orders documented by the provider and received inpatient services exceeding 10 days. There were 17 of 30 accounts that had the first IM delivered within the set guidelines and had all the Medicare required documentation. Twelve accounts did not have the first IM in the medical records and one account had the IM delivered after two calendar days from the admission date. Of the 29 discharged patients, six accounts had the follow-up IM delivered within the set guidelines and had all the Medicare required documentation. Twelve accounts did not have follow-up IM in the medical records. Of the seventeen accounts with a follow-up IM form in the medical records, eleven had documentation that was discussed with the patient or representative verbally or telephonically but did not have the "additional information" section annotated as required or documentation that the hard copy was mailed to the representative.

Recommendations

We recommended that the PFS management and CE management reeducate the staff regarding the requirements for providing the first IM and the follow up IM, review and update as necessary the current process for completing the first and follow-up IM, and perform regular prospective reviews on Medicare inpatient accounts to ensure compliance with the IM and follow up IM completion according to Medicare requirements.

Felicia Turnley, Chief Executive Officer, MHP and Patrick Connor, Chief Financial Officer, MHP agreed with the findings and recommendations of this audit and have provided an action plan.

Compliance Audit of the Primary Care Center's Outpatient Sickle Cell Day Center at Memorial Regional Hospital

Background

Sickle cell disease (SCD) is a group of inherited red blood cell disorders. The hemoglobin (a protein that carries oxygen) is abnormal, which causes the red blood cells to become hard and sticky, and sickle shaped, which occlude the small blood vessel stopping the normal flow of blood and oxygen,

causing severe pain. The sickle cells die early, causing a constant shortage of red blood cells and other serious complications.

The Sickle Cell Day Center (SCDC) is a stand-alone hospital outpatient facility, under the operations of Memorial Primary Care (MPC). Adult patients who are experiencing uncomplicated acute painful sickle cell crisis are treated with prompt, aggressive treatment on an average, treatment delivery of about six hours, avoiding hospital admission and fewer emergency department (ED) visits. These patients may receive hydration infusions, injections, pain management, and monitoring on an outpatient basis and are discharged after treatment; if stable.

According to the American Medical Association (AMA) Current Procedural Terminology (CPT) guidelines, charges for the initial code (reason for the encounter) of infusions and injections in facilities are based on a hierarchy. Only one initial service CPT code should be charged unless the protocol or patient condition requires that two separate intravenous (IV) sites be utilized. A minimum time duration of 31 minutes of hydration infusion calculated by the start and stop times is required to bill hydration service. IV infusion, hydration, IV injection and multiple medications, including controlled substances, are used in SCDC Services. SCDC uses the automated dispensing cabinets (ADC) to automate the distribution, management, and control of medications. All medications administered are documented in the Medication Administration Record (MAR) by registered nurses.

Observations

All 30 dates of service reviewed were for patients diagnosis with sickle cell and who were experiencing acute painful sickle cell crisis. Thirty dates of service had focused history and physical assessment, orders for services delivered and documentation that supports medical necessity by provider. Of the 30 dates of service, two patients were transferred to ED for medically necessary further evaluation. All 30 dates of service had documentation of vital signs, pain assessment, focused physical assessment, pain level reassessment, individualized plan of care and oxygen saturation level after administration of every pain medication. Discharge or transfer vital signs with pain level and note about the patient's mode of transportation for safe discharge were also documented by registered nurses.

All 30 dates of service had documentation of hydration and multiple IV injections administered. All hydration administered had start and stop times documented. Of the 168 IV injections administered, we noted twenty-eight non-narcotic medications did not have waste documented in the ADC. There is no regulation or MHS policy specific to non-narcotic waste procedure however, according to pharmacy management, it is an expectation that registered nurses waste and document unused medications. Subsequent to this finding, management has developed a written departmental process of non-narcotic waste and reeducated registered nurses.

Service charges for hydration and IV injections are entered by registered nurses at SCDC. All 30 hydration and 168 IV injections reviewed were coded and charged appropriately according to CPT guidelines. The claim on one date of service was denied and has been rebilled with corrections. Twenty-nine dates of service were reimbursed appropriately.

Recommendations

None.

Peter Powers, Administrator and Chief Executive Officer, MRH, and Walter Bussell Chief Financial Officer, MRH, agreed with the results of this audit. Since there were no recommendations,

an action plan was not required.

Compliance Audit of the Obstetric Emergency Department at Memorial Hospital Miramar

Background

Memorial Hospital Miramar (MHM) has a dedicated Emergency Department (ED) for Obstetric (OB) patients above 20 weeks of pregnancy. As an ED, OB ED must comply with the Emergency Medical Treatment and Labor Act (EMTALA) regulations to provide a medical screening examination (MSE) and stabilizing treatment for patients with an emergency medical condition (EMC) including active labor, regardless of their ability to pay. EMTALA violations result in large fines and possible termination of the Medicare provider agreement for the hospital involved.

The Centers for Medicare and Medicaid Services (CMS) require hospitals to report facility resources for ED visits using Current Procedural Terminology (CPT) evaluation and management (E/M) codes. CMS instructed hospitals to develop their own internal guidelines for reporting E/M codes for ED encounters. As with the Memorial Healthcare System (MHS) ED protocol, the OB ED developed a Facility Charge Calculator (FCC) points-based guideline specific to OB services to determine the level of service based on the intensity of patient care and resources utilized for the patient during the encounter. The purpose of this audit was to determine if the OB ED at MHM is in compliance with EMTALA regulations, and to determine if documentation supports the level of service and the accuracy of charging, coding, and billing.

Observations

We noted that requirements for EMTALA were met including appropriate signage, logs and on-call physician lists. There were timely MSE, and treatment documented for the 31 out of 35 accounts reviewed. The remaining four accounts were non-emergent direct admissions to the Labor and Delivery Department (L&D) but were registered in the OB ED. We were unable to find the time when registration was completed for all 35 accounts in the Encounter Events Summary. However, we verified that all patients received a MSE and treatment upon arrival. Subsequently, Patient Financial Services (PFS) management requested an enhancement in Epic Stork, our OB electronic health records, to show the time when registration was completed. An opportunity for improvement was noted on two accounts where we were unable to find the documentation for the Maternal Fetal Triage Index (MFTI) used in triage to determine urgency of further evaluation and management.

We reviewed the FCC used in OB ED and noted that on all 35 accounts, the historical FCC scores did not match the appropriate level of service and CPT code charged. We also noted that some documented items did not accumulate points. Subsequently, the Epic Stork Team updated the OB ED Encounter Summary report so that the total FCC score corresponded to the appropriate level of service and CPT code charged for the encounter. As the FCC score range is large, the correction of the FCC points did not affect the level of service or the reimbursement on the accounts reviewed. We also noted the charges incurred in the OB ED for the four direct admission accounts did not affect reimbursement as the charges were included in the payment for the hospital stay according to contractual arrangements.

Recommendations

We recommended that OB ED management review the direct admission process and reeducate nurses to ensure direct admissions are not registered in OB ED. We recommended OB ED management routinely monitor the direct admissions to L&D to ensure that charges are not

incurring in the OB ED, and correct, if necessary. We recommended OB ED management continue to reeducate nurses on the completeness of documentation and include monitoring the MFTI documentation in their routine chart audits. We recommended PFS management audit the OB ED encounter registration timing for appropriateness. We recommended OB ED management routinely monitor the OB ED charges for appropriateness and verify that the FCC score is supported by documentation. We recommended OB ED management work with the Epic Stork Team when issues are identified during routine OB ED charge audits.

Stephen Demers, Chief Executive Officer, MHM, and Veronica Bautista, Chief Financial Officer, MHM agreed with the findings and recommendations of this audit and have provided an action plan.

Compliance Audit of High Risk Obstetrics Evaluation and Management Services and Procedure for Memorial Physician Group Professional Coding and Billing

Background

Memorial Healthcare System (MHS) is the leader in Broward County births with three Family Birthplace facilities that deliver more than 50% of all the babies in the county. Memorial's Maternity Team has staff with specialized training and experience with high risk pregnancies. The multidisciplinary care team includes high risk obstetricians, maternal-fetal medicine specialists, and Certified Nurse Midwives (CNMs). As part of an academic medical institution, the physicians also research new treatments and teach residents that are next generation of doctors.

Physician services are the professional services that include diagnosis, therapy, surgery, consultation, and care plan oversight.

Evaluation and Management Services

A medically reasonable and necessary evaluation and management (E/M) visit documents the patient's medical needs and medical decisions on the appropriate measures of care for specific clinical circumstances. Billing for an E/M service requires the selection of a Current Procedural Terminology (CPT) code that best represents a patient type, place of service, and level of E/M service performed. Place of service can be the physician's office or other outpatient facility, hospital inpatient, Emergency Department (ED) and telemedicine. Modifiers are appended on a claim for additional information. Advanced Practice Registered Nurses (APRNs) including CNMs can report services independently, or under the incident-to guidelines, or shared/split visit guidelines. A visit provided by a teaching physician with a resident physician aiding in patient care is billed using an appropriate modifier. Physician and teaching physician E/M services can be provided through telehealth. Telehealth billing codes are based on the provider's documentation that the telecommunications used was either audio-video or audio only and appended using an appropriate modifier.

The global Obstetrical (OB) care package provided for routine or uncomplicated maternity cases includes antepartum (during pregnancy), delivery, and postpartum up to 6 weeks post-delivery care. The physician group that provides the complete global OB package reports the services with global maternity CPT codes after the delivery. There are circumstances when the physicians and CNMs from different groups provide individual components of the global OB package which may require itemization or split billing and reimbursement. ED and hospital services that are split billed when the patient is seen by two different physician groups would break the global package. For patients admitted to the hospital with inpatient or observation status, the hospital discharge day

management E/M visit is a face-to-face service provided by the attending physician. The service is reported with a CPT code based on time spent in discharge services of 30 minutes or less, or more than 30 minutes. As per CPT guidelines, medical complications associated with pregnancy and medical problems complicating labor and delivery that require additional resources may be reported separately. The purpose of this audit was to determine whether documentation and coding complied with the Centers for Medicare and Medicaid (CMS) and payor requirements when billing for high risk obstetrics E/M services.

Observations

We reviewed 144 E/M services accounts for 13 physicians and eight APRNs with some findings that may overlap. Of the 144 accounts reviewed there were thirty-two accounts for teaching physician services, two for telehealth services, 39 accounts required modifiers, 12 accounts for discharge services, and 37 accounts for Emergency or ED services. There were no accounts for telephone, incident-to and for shared visits. Out of 144 accounts, we noted that for 110 accounts the E/M CPT codes were appropriate for the services provided. There was one account coded at two or more E/M service levels lower than the supported documentation. The documentation for 30 accounts supported a different CPT code or were not separately reportable. The documentation for three accounts was insufficient to support billing for services.

We noted that time was not documented in the 12 accounts for discharge services and were appropriately coded using the lower level CPT code. Thirty-one of 32 accounts met CMS teaching physician guidelines. Modifiers were appropriately applied to 20 of 39 accounts and in the remaining accounts, reimbursement was not affected due to modifiers being informational in nature. Fourteen accounts had ICD-10 codes that were appropriate, supported by documented medical necessity. In the remaining accounts, we noted that medical record documentation supported additional or different ICD-10 codes with coding guidelines.

Recommendations

We recommended that MPG Business Office correct and rebill or refund accounts as appropriate. We recommended that the Director of Billing and Compliance reeducate providers on medical record documentation, coding, and billing to support medical necessity and services billed, as MPG Business Office does not code E/M or ICD-10 codes. We recommended continued training for the providers on documenting and reporting discharge and ED services appropriately.

Mario Salceda-Cruz, Chief Operating Officer, MPG and Esther Surujon, Chief Financial Officer, MPG agreed with the findings and recommendations and have provided a detailed action plan.

Procedures

Background

The global Obstetrical (OB) care package allowance is for routine or uncomplicated maternity cases that includes antepartum (during pregnancy), delivery, and postpartum up to 6 weeks post-delivery care. The physician group that provides the complete global OB package reports these services, including urinalysis services, with global maternity Current Procedural Terminology (CPT) codes after the delivery. CPT codes are used to report services and procedures performed. Modifiers are appended to the CPT codes to report services that are altered under certain circumstances. International Classification of Diseases, 10th Revision (ICD-10–CM) diagnosis codes are used to indicate the reason for care. Services may also be performed and reported as teaching physicians training the resident physicians as per Centers for Medicare and Medicaid

Services (CMS) guidelines. Fetal non stress testing (NST) may be reported separately when medical necessity is documented with the reason for the visit, test interpretation, and test duration. The Physician Payments Sunshine Act (Sunshine Act), part of the Affordable Care Act (ACA) of 2010, is a federally mandated disclosure program that requires manufacturers and distributors of medical devices and drugs to report payments to physicians, nurse practitioners, CNMs, and teaching hospitals. These payments are publicly accessible through the Open Payments Program.

The purpose of this audit was to determine whether documentation and coding complied with CMS and payer requirements when billing for High Risk OB procedures.

Observations

A comprehensive audit scope was used for review in all 124 accounts with some accounts having more than one finding. We noted that for 74 accounts, the CPT procedure codes used for billing were supported by medical record documentation. Of the remaining 50 accounts, there were 33 urinalysis services performed that were included in the global OB package billing and were separately billed. There were seven accounts in which documentation supported billing for different or additional CPT codes than billed. There were 10 accounts in which documentation did not support billing for the services. Of these 10 accounts, eight were for fetal non stress testing (NST) and two for other procedures. There were 19 accounts for services performed as a teaching physician and all met the CMS teaching physician guidelines. There were 43 accounts that needed a billing modifier, of which 23 were appropriately applied. Reimbursement was not affected due to modifiers being informational in nature. We noted that 23 accounts used the ICD-10-CM codes in accordance with the coding guidelines and opportunities for improvement were identified with assigning accurate ICD-10-CM diagnosis codes in the remaining accounts. There were five accounts in which payment was denied for duplicate claims, request for additional documentation, or eligibility issues. We collected and analyzed the CMS Open Payments data for each of the physicians and CNMs in this audit and there were no findings since this is a new group and data has not been posted since they joined MPG. We noted that there were two physicians and six CNMs who were not registered with the CMS Open Payments.

Recommendations

We recommended that Memorial Physician Group (MPG) Business Office correct and rebill or refund accounts as appropriate. We recommended providers be reeducated on medical record documentation, coding, and billing of routine and non-routine global OB care services. We recommended MPG Business Office develop, implement, and monitor for compliance with documentation, coding, and billing of urinalysis and NST services. We recommended MPG Business Office coordinate with Information Technology (IT) to update Epic with the services included in the global OB care package. We recommended MPG Business Office initiate a retrospective review of urinalysis and NST services to identify charge capture errors and correct and rebill if appropriate. We recommended that MPG Administration ensure that Open Payment covered recipients are registered and updated in the Open Payments system and CMS Identity Management (IDM) and to monitor the data on their behalf.

Mario Salceda-Cruz, Chief Operating Officer, MPG and Esther Surujon, Chief Financial Officer, MPG, agreed with the findings and recommendations and have provided an action plan, which is attached.

D. Services Provided by Protiviti

A list of Services Provided by Protiviti for the quarter will be discussed during the meeting.

E. Other Reports

Investor Log

The Investor Contact Log for the quarter is attached for your review. See Exhibit C.

Non-Audit Engagements

A list of RSM and Zomma Group Non-Audit Engagements for the quarter is attached for your review. See Exhibit D.

Compliance Environment

A discussion of Nationwide Audit and Investigation Activities for the quarter will be held during the meeting.

VI. OPEN LINES OF COMMUNICATION

A. Hotline Calls

During the quarter, 30 calls, two of which were callbacks, were placed to the System's Compliance Hotline covering 22 new topics and two old topics. One topic was a compliance allegation (one call). One topic was a HIPAA Privacy allegation (one call). One topic was quality of care or service allegations (one call). All of the calls were investigated and one of the compliance allegations was substantiated.

Finally, three topics were informational (three calls), and 16 new topics and two old topics (22 calls, two callbacks) were employee-management relations issues. The employee-management relations issues have been forwarded to the Employee Relations and Human Resources Departments.

VII. ENFORCEMENT & DISCIPLINE

Sanction checks were conducted of employees, physicians, vendors, volunteers, and students. None were sanctioned during the quarter.

SBHD Construction Projects
Period Ending 7/31/2023

Exhibit A

	Ambulatory Surgery Center ANF Group, Inc. #450218ASC MHM	Urgent Care Center Miami Gardens Gerrits Construction Inc. #650322 MHS	Family Birthplace Turner Construction Co. #400121 MHS	Wind Retrofit Turner Construction Co. #409020 MRH	Family Birthplace Turner Constuction Co. #400622 MRH	Outpatient Behavioral Health ANF Group, Inc. #401122 MRH
	Amount	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	$ 5,589,844	$ 1,929,942	$ 3,658,618	$ 4,924,483	$ 43,850,159	$ 3,336,927
Prior Change Orders	(1,340,949)					(470,053)
Budget Transfer			-			
Current Change Orders						
Prior Owner Purchase Orders		(290,000)	(647,529)	(280,691)	(9,703,000)	375,787
Current Owner Purchase Orders		126,800	201,969	9,744		20,075
Current Contract Sum to Date	$ 4,248,894	$ 1,766,742	$ 3,213,058	$ 4,653,537	$ 34,147,159	$ 3,262,736
Previous Payments	4,124,271	536,034	2,479,331	4,245,530	2,153,637	2,735,416
		5 175,104	15 159,453	20 156,613	4 1,000,349	10 141,706
		6 334,559	16 108,172	21 133,495	5 1,437,078	11 212,784
		7 231,832	17 214,796	22 13,211	6 1,753,574	12 160,563
Total Payments	4,124,271	1,277,529	2,961,752	4,548,849	6,344,638	3,250,469
Balance	$ 124,623	$ 489,213	$ 251,306	$ 104,688	$ 27,802,521	$ 12,267
Owner Purchased Materials						
Retainage		52,458	75,488		201,596	
Payments	4,124,271	1,277,529	2,961,752	4,548,849	6,344,638	3,250,469
Work completed	$ 4,124,271	$ 1,329,987	$ 3,037,239	$ 4,548,849	$ 6,546,234	$ 3,250,469
Status	Active	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 7/31/2023

Exhibit A

	MOB II Second Floor Pediatric Fit Out Thornton Construction Co. Inc. #800122 MHM	MOB Women Center ANF Group, Inc. #450218 MHM	Memorial Cancer Center Expansion DPR Construction #431019 MHW	Hurricane Hardening Thornton Construction Co. #410121 MRHS	Family Birthplace Replacement Thornton Construction Co. #430321 MHW
	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	$ 10,650,417	$ 35,067,236	$ 86,165,924	$ 13,613,113	$ 2,110,655
Prior Change Orders		(5,101,409)	(15,603,724)		
Budget Transfer					
Current Change Orders					
Prior Owner Purchase Orders	(1,799,954)	(750,000)		(2,984,941)	18,616
Current Owner Purchase Orders			81,964		242,404
Current Contract Sum to Date	$ 8,850,463	$ 29,215,826	$ 70,644,164	$ 10,628,172	$ 2,371,674
Previous Payments	2,775,444	27,790,363	48,288,749	8,814,331	2,330,107
3	976,697		19 2,386,209	15 397,329	
4	423,684		20 2,395,740		
5	532,792		21 2,484,100		
Total Payments	4,708,617	27,790,363	55,554,798	9,211,660	2,330,107
Balance	$ 4,141,846	$ 1,425,464	$ 15,089,366	$ 1,416,511	$ 41,568
Owner Purchased Materials					
Retainage	187,219		2,368,482	484,824	
Payments	4,708,617	27,790,363	55,554,798	9,211,660	2,330,107
Work completed	$ 4,895,836	$ 27,790,363	$ 57,923,280	$ 9,696,485	$ 2,330,107
Status	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 7/31/2023

Exhibit A

	Lift Station & Force Main Thornton Construction Co. #401720 MHM	Memorial Cancer Institute ANF Group, Inc. #401820 MHS	Emergency Department Trauma Center Turner Construction Company #400222 MRH	JDCH Vertical Expansion Robins & Morton Group #460117 JDCH
	Amount	Amount		Amount
Original Contract Sum	$ 4,677,865	$ 3,318,035	$ 16,401,716	$ 108,993,259
Prior Change Orders		(642,606)		
Budget Transfer				
Current Change Orders		64,000		
Prior Owner Purchase Orders	(526,524)	182,424	(3,300,002)	(15,093,946)
Current Owner Purchase Orders	69,261			
Current Contract Sum to Date	$ 4,220,601	$ 2,921,853	$ 13,101,714	$ 93,899,313
Previous Payments	3,943,773	2,808,328	2,300,095	84,557,086
	12 276,828		5 383,676	26 2,405,985
			6 549,184	
			7 363,717	
Total Payments	4,220,601	2,808,328	3,596,672	86,963,071
Balance	$ (0)	$ 113,525	$ 9,505,042	$ 6,936,241
Owner Purchased Materials				
Retainage			85,735	
Payments	4,220,601	2,808,328	3,596,672	86,963,071
Work completed	$ 4,220,601	$ 2,808,328	$ 3,682,406	$ 86,963,071
Status	Active	Active	Active	Active

Memorial Healthcare System
RFP and Competitive Quote Audits

	RFPs	Current Phase - 1st Quarter FY 2024	Audited Through	Exceptions
1	Investment Advisory	Selection	Analysis	None
2	Disaster Debris Removal and Disposal	Selection	Analysis	None
3	Call Center Outsourcing	Analysis	Design	None
4	New Cancer Center Café Vendor RFQ at MHW	Analysis	Design	None
5	Talent Acquisition Center Exterior Painting RFQ	Analysis	Design	None
6	Surgical and Critical Care Tower Addition at MRH	Analysis	Design	None
7	Retail Food Service RFQ at JDCH	Advertising/Mailing	Advertising/Mailing	None
8	Valet Parking Service, Booth Attendant and Shuttle Services	Selection	Analysis	None
9	Care Coordination Center Software	Selection	Selection	None
10	Clinical Trial Management System	Selection	Selection	None
11	Clinical Engineering Computerized Maintenance Management System	Oral Presentation	Analysis	None
12	Case Management Utilization Review	Selection	Selection	None
13	Release of Patient Medical Information	Selection	Selection	None

Memorial Healthcare System
RFP and Competitive Quote Audits

	Completed Competitive Quotes	Amount $	Exceptions
1	Cloud Access Security Broker Licenses for MHS	447,635	None
2	Three Year License and Support Renewal of Multi Factor Authentication Software for MHS	2,582,118	None
3	One Year Media Relations Contract for MHS	180,000	None
4	New GE Definium Tempo X-Ray Technology for MHW	250,926	None
5	EPIC's Healthy Planet Population Health Application for MHS	214,000	None
6	Three Year Patient Rounding Software for MHS	736,698	None
7	Three Year Extension to Microsoft Services with Additional Licences for MHS	2,954,807	None
8	Three Year Microsoft Teams and 365 Enterprise Agreement for MHS	11,057,648	None
9	Consultant for Inventory Par Redesign Project at MHW	676,600	None
10	Management of MHS Social Media Platforms	468,000	None
11	MHS Network Infrastructure Software	517,350	None
12	Network Access Switches for System Upgrade at MRH	558,567	None
13	Support Service for Windows Servers MHS	229,810	None
14	Surgical Equipment for Operating Room at MHW	220,000	None
15	Medical Equipment for Memorial Cancer Institute	242,373	None
16	One Year Maintenance Renewal for IBM Hardware and Software at MHS Datacenters	533,227	None
17	Imaging Equipment for MHM	173,297	None
18	Supply Chain Commodity and Vendor Contracts Realignment	220,000	None
19	Surgical Services Equipment for MHM	425,000	None
20	Surgical Services Equipment for MHW	425,000	None
21	Bedside Monitors for MRHS	545,383	None
22	Second Floor Pediatric Specialties Center at MHM MOB	1,698,946	None
23	Year Two Subscription to Workday Succes Plan for MHS	273,000	None
24	Hardware & Software Maintenance Renewal for MHS Datacenter Servers	533,227	None
25	Endoscopy Equipment Replacement at MHW	156,826	None
26	Patient Imaging Cloud Services for MHS	117,000	None
27	Endoscopy Equipment for MHM MOB	715,894	None
28	Service Agreement for Imaging Equipment at JDCH	599,999	None
29	Metal Doors and Hardware for Family Birthplace Project at MRH	521,975	None
30	Quality Control Materials for Chemistry Analyzers for MHS	194,315	None

Exhibit C

Memorial Healthcare System
Investor Contact Log
Fiscal Year 2024

Quarter: Ended	Contact:	Representing:	Discussion:
July 31,2023	Beth Wexler	Moody's Investor Service	Post-ratings discussion
October 31, 2023			
January 31, 2024			
April 30, 2024			

Exhibit D

Memorial Healthcare System
Non Audit Engagement Report
Q1 FY 2024

Quarter Ended	RSM US LLP Engagement:		
Q1 FY2024	For professional services rendered and expenses incurred in connection with the preparation of Memorial Healthcare System YE 04/30/2022 tax returns.	$	15,000
	For professional services rendered and expenses incurred in connection with implementing GASB 87 Technical Lease accounting.	$	7,875
	Total	$	22,875
Q1 FY2023	Total spend, provided for comparative purpose	$	46,645

Quarter Ended	Zomma Group LLP Engagement:		
Q1 FY2024	For professional services rendered and expenses incurred in connection with Non Audit Engagements.	$	-
Q1 FY2023	Total spend, provided for comparative purpose	$	-

Memorial Healthcare System

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: September 5, 2023

From: Dorinda Segovia, Vice President, Pharmacy Services, MHS
Scott Davis, Vice President, Reimbursement and Revenue Integrity, MHS

Subject: **Action Plan: Compliance Audit of the 340B Program at Memorial Healthcare System - FY 2024 First Quarter**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend 340B management review the claims missing the original order in Epic, and reverse the 340B claims and charges, as appropriate to regulations and guidelines.	All unlinked override dispenses exceeding 24-48 hours from date of dispense are to be credited in Epic, on the patients account by pharmacy. Physician, Pharmacy and Nursing leadership (Directors and Chiefs) to review: • Override list • Policies • Retrain staff • Communicate all updates to this process once review is completed.	1/31/2024
We recommend 340B management review all Automated Dispensing Cabinet (ADC) overrides	Pharmacy is to pull daily override reports and follow up with nursing leadership on overrides remaining	9/25/2023

retrospectively to a year to identify patients who did not meet the 340B eligibility because of missing the original order and reverse the claim, if necessary.	unlinked, without an order past 24-48 hours. Any items remaining unlinked past 48 hours will be credited by Pharmacy. This change is to begin immediately at the release of this Action Plan. As any unlinked overrides pass the 24-48 hours, Pharmacy is to credit in Epic all drug overrides to be in accordance with billing regulations as well as Board of Pharmacy and 340B regulations.	
We recommend pharmacy and nursing leadership review and update "PH20-52 Medication Overrides" and "PH30-02 Physician Orders/ Telephone/Verbal/Fax/ Transcription Implementation" policies to reflect the Centers for Medicare and Medicaid Services Comprehensive Error Rate Testing policy on timeliness of orders.	Recommendation to Pharmacy and Nursing Leadership & Policy committee: Review of Requirements for the Payment of Medicare Claims and Medicare Integrity Manual **MHS Documents that need revisions:** PH 20-52: policy should specify override review daily and overrides reconciled and linked within 24 to 48 hours from dispense. PH 30-02: Update Policy to include 24-48 hours. Willow Tips & Tricks Tip Sheet, internal information created needs to be updated with recommendations stated above.	1/31/2024
We recommend pharmacy management at each MHS hospital review their existing process for reconciling ADC overrides to an original order and develop a standardized process. applicable to all facilities.	All sites to only use Epic/Clarity report for daily review. Report edits submitted to include the following: 340B Director submitted **REQ0686974** Add: Med ID Charge code- if possible NDC Dispensed quantity	9/25/2023

	Patient charged amount and quantity Adjust report format so that it can be filtered by column header/Pivot	
We recommend pharmacy management work with nursing management in reeducating nurses on the medication overrides policy to ensure provider orders are obtained and documented in Epic.	Pharmacy, Nursing, and Physician leadership to bring to their respective committees and address education needs preceding of policy reviews.	1/31/2023
We recommend pharmacy management work with the Epic Team to develop a system to ensure medication overrides have linked provider orders entered in a timely manner in Epic.	All sites to use Epic/Clarity report link and have Pharmacy staff pull this report daily for to resolve overrides. From May 1, 2016 – current date all charges for Medicare, Medicare HMO, Medicaid, Medicaid HMO, Tricare/Champus would all be subject to federal compliance requirements. All unlinked dispenses will need to be reversed on patients chart for orders/ANI's that don't exist. If an order does exist, link the override to the order. • Additional follow-up is needed with Kim Almonte and Scott Davis prior to correcting charges. Moving forward, all overrides for all patient types, all payors are to have ADC overrides investigated and linked between 24-48 hours. Unlinked overrides past 48 hours will lead to crediting the dose removed from the ADC by Pharmacy. Recommendation for Pharmacy to work with Epic and Charge team, for Pharmacy to research if there's a way to hold patient charges on Overrides pending further review. If	1/31/2024

	charge team can develop Workqueue (WQ), Pharmacy would fully manage WQ to prevent charges on patients account. WQ Report would resolve as Pyxis ADC is resolved.	

cc: K. Scott Wester, President and Chief Executive Officer, MHS

Dorinda Segovia,
Vice President, Pharmacy Services

Scott Davis,
Vice President, Reimbursement and Revenue Integrity

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: July 28, 2023

From: Peter Powers, Chief Executive Officer, MRH

Walter Bussell, Chief Financial Officer, MRH

Subject: **Action Plan: Compliance Audit of Documentation and Billing of the Diabetes Self-Management Education and Support Services Program in the Diabetes and Nutrition Center at Memorial Regional Hospital**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend the (diabetes Self-Management Education and Support Services) DSMES program management reeducate staff on documenting and charging time.	The correct process for documenting and charging time reviewed with staff. Updated workflows implemented to include audit and self-governance process for ongoing accountability.	6/15/23
We recommend the DSMES program management collaborate with Information Technology to review and update the current order/referral template in Epic to include all Medicare's required components.	Service Now ticket placed with DIO. ClinDoc support initiated for referral enhancement to meet CMS Requirements.	10/1/2023
We recommend the DSMES program management develop a process to ensure all orders from providers include all Medicare required components, that the patient has a diagnosis of diabetes, and the required documentation are received from ordering provider.	Prescription process and format changed to ensure compliance with CMS guidelines. The DSMES now validates referring provider prescriptions for compliance with regulatory requirements prior to patient appointment.	6/5/23
We recommend the DSMES program management review and comply with the Medicare requirements for providing and billing (diabetes self-management training) DSMT.	Management team will monitor and stay current with CMS and ADA guidance for program compliance.	Ongoing

We recommend Accounts Receivable Management (ARM) rebill the two identified dates of service with inaccurate units and refund the identified dates of service that did not meet Medicare requirements.	Management team is working with MHS Revenue Cycle Management to rebill the identified errors.	In process
We recommend the DSMES program management review Medicare and Medicare Advantage accounts billed for DSMT retrospectively to determine compliance with Medicare requirements. If errors are noted, the DSMES management collaborate with ARM to correct, refund or rebill accounts identified with errors.	Management team will consult with MHS Revenue Cycle Management and the Compliance Department to determine the appropriate process and actions for a retrospective review.	10/1/2023

cc: K. Scott Wester, President and Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: August 28, 2023

From: Peter Powers, Administrator and Chief Executive Officer, MRH
Walter Bussell, Chief Financial Officer, MRH

Subject: **Action Plan: COMPLIANCE AUDIT OF DOCUMENTATION AND BILLING FOR ASSESSMENT OF ANTIBODY TO HUMAN LEUKOCYTE ANTIGEN (HLA) CLASS I WITH HIGH-DEFINITION QUALITATIVE PANEL (CPT CODE 86832) AT MEMORIAL REGIONAL HOSPITAL**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend Memorial Transplant Institute (MTI) management perform routine audits of the laboratory orders of HLA testing to ensure accuracy and appropriateness.	The transplant leadership team will routinely audit UM laboratory invoices and reconcile discrepancies between pre and post HLA testing as compared to patients' transplant dates.	11/30/23
We recommend MTI management work with Information Technology (IT) to develop a process/system to review the HLA orders for accuracy and required components prior to being sent to the reference laboratory.	MTI will collaborate with IT to modify codes for accurate components, and to implement hard-stops/ warnings for ordering providers to ensure patient pre- or post-transplant status corresponds with appropriate order.	12/8/23
We recommend MTI management work with IT to develop a process to reconcile histocompatibility lab results to ensure appropriateness of University of Miami Histocompatibility laboratory invoicing and Medicare billing.	Collaborate with IT for an EPIC report to identify orders placed that were never processed with additional modifications to create alerts when pre or post phases do not align with the respective transplant dates.	12/15/23

cc: K. Scott Wester, President and Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: August 7, 2023

From: Stephen Demers, Chief Executive Officer, MHM
Veronica Bautista, Chief Financial Officer, MHM

Subject: **Action Plan: COMPLIANCE AUDIT OF THE MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON) AT MEMORIAL HOSPITAL MIRAMAR**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that the Clinical Effectiveness management reeducate the staff regarding the requirements for compliance with providing the MOON according to the Medicare guidelines.	CE Director and Manager will re-educate CE staff in all compliance topics for MOON letters. One on one education is underway. A new staff member was hired and is undergoing training to support MOON compliance. Re-education reviews quarterly as part of ongoing compliance.	September 1st, 2023 (current team) Ongoing for new staff hires subsequent to Compliance Audit
We recommend the Patient Financial Services Team in the Emergency Department continue to help in providing the MOON to patients when there is sufficient time prior to transfer to the floor.	Reinforce education to ER PFS team regarding correct completion of the MOON form via huddles or one-on-one education, as well as email format. Reminder/educational email to ER PFS team will be repeated quarterly hereafter.	September 30, 2023 (current team) Ongoing for new hires and for reinforcement with all ER PFS staff

	Continued use of electronic format which date/time stamps receipt of form.	
We recommend the Clinical Effectiveness management review current process for completing MOONs and update as necessary to ensure compliance with Medicare requirements.	Process was reviewed, updated, and discussed with staff. A job aid in compliance with CMS guidelines was developed and discussed with staff. CE Director and CMO recommend addition of the following for the "Additional Info (Optional)" area on the MOON/HOON forms: "e.g. discussed via phone" so as to prompt team members to include that pertinent information in that box on page 2 rather than in the patient signature box.	September 1st, 2023 Ongoing review as well for any CMS updates which may need to be addressed. Recommended addition to the form to be reviewed amongst all CE Directors and via appropriate chain of command for potential adoption.
We recommend the Clinical Effectiveness management perform regular prospective reviews on Medicare observation accounts to ensure compliance with the completion of Medicare requirements.	CE Director (or designee) is conducting daily audits to ensure compliance with CMS requirements, identify deficiencies, and provide immediate resolution. PFS Manager is similarly conducting prospective audits. This is ongoing with quarterly reporting to A-team until further notice.	Commenced August 1st, 2023. Ongoing for quarterly reporting to A-team

cc: K. Scott Wester, President and Chief Executive Officer, MHS

Memorial Healthcare System

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: September 12, 2023

From: Felicia Turnley, Chief Executive Officer, MHP
Patrick Connor, Chief Financial Officer, MHP

Subject: **Action Plan: COMPLIANCE AUDIT OF THE IMPORTANT MESSAGE FROM MEDICARE (IM) NOTICE AT MEMORIAL HOSPITAL PEMBROKE**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that the Patient Financial Services (PFS) management reeducate the staff regarding the requirements for compliance with providing the first IM according to the Medicare guidelines.	Staff re-education took place during huddles, via e-mail and individually with team members who visit patients on the patient units between the dates of 08/14 thru 09/08. Additional training is scheduled 09/25 and 09/28 during staff monthly meeting. IMM process will be assessed and coached during annual employee competency evaluation.	September 30, 2023 Ongoing
We recommend that the Clinical Effectiveness (CE) management reeducate the staff regarding the requirements for compliance with providing the follow-up IM according to Medicare guidelines.	Staff was re-educated on the CMS requirements to complete IMM correctly and within the time frame required by CMS. Training was completed during weekly staff meetings on 7/12/23, 7/19/23, 7/25/23, 8/30/23. New process of workflow has been implemented and improvements have been noted.	9/8/23

	IMM process will be assessed and coached during annual employee competency evaluation.	Ongoing
We recommend the PFS management and CE management review current process for completing the first and follow-up IM and update as necessary to ensure compliance with Medicare requirements.	Leadership review was conducted to include CE Director, PFS Director and CFO reviewing each department's workflow and plan for improvement. Review included CMS requirements to complete forms correctly, staff designated to complete forms and action plan to improve the above.	8/24/23
We recommend the PFS and CE management perform regular prospective reviews on Medicare inpatient accounts to ensure compliance with the completion of Medicare requirements.	CE and PFS Managers will audit IMM compliance on a monthly basis. Both CE and PFS Leaders will report results regularly in staff meetings.	Beginning in September 2023

cc: K. Scott Wester, President and Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: August 28, 2023

From: Stephen Demers, Chief Executive Officer, MHM
Veronica Bautista, Chief Financial Officer, MHM

Subject: **Action Plan: COMPLIANCE AUDIT OF THE OBSTETRIC EMERGENCY DEPARTMENT AT MEMORIAL HOSPITAL MIRAMAR**

Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend Obstetric (OB) Emergency Department (ED) management review the direct admission process and reeducate nurses to ensure direct admissions are not registered in OB ED.	Re-education of staff that only OB ED patient Versus badges enter the OB ED Bay. Versus badges for patients awaiting bed in L&D or AP must be placed in the cabinet to avoid inadvertent OB ED charges for direct admits. Re-education completed through team meeting, shift huddle & weekly newsletter.	09/08/2023
We recommend OB ED management routinely monitor the direct admissions to (Labor and Delivery) L&D to ensure that charges are not incurring in the OB ED and correct, if necessary.	Supply Chain coordinator who posts charges will review and validate charges of all direct admissions to verify that no OB ED charges incurred and correct if necessary.	On-going
We recommend OB ED management continue to reeducate nurses on the completeness of documentation and include monitoring the Maternal Fetal Triage Index (MFTI) documentation in their routine chart audits.	Re-educate / review documentation requirements with staff through shift huddles, team meeting & weekly newsletter. Audit 50 charts/ month for compliance by OBED leadership	Re-education 10/15/2023 Audit - Ongoing

We recommend OB ED management routinely monitor the OB ED charges for appropriateness and verify that the Facility Charge Calculator (FCC) score is supported by documentation.	Audit OB ED encounter summary of 50 charts/ month to verify appropriateness of FCC by OBED leadership.	On-going
We recommend OB ED management work with the Epic Stork Team when issues are identified during routine OB ED charge audits.	Review available EPIC OB ED charge report weekly to identify any issues, which would then be reviewed with EPIC Stork Team.	Ongoing
We recommend Patient Financial Services management audit timing of Obstetric (OB) Emergency Department (ED) encounter registration for appropriateness similar to the existing audit done for regular ED.	Requested from MHS Epic Optimization Team to enable viewing of registration start and stop times for OB ED patients. Sherlock ticket (#7974981) was in turn placed with Epic. Options will be evaluated by IT Team and an approach selected to ensure that this required information is viewable. Testing will be done in POC EPIC environment and optimal process will be put into production for validation. Once validated, PFS Management will begin sample audits to monitor the timing of registrations. Said audits will continue in perpetuity.	11/01/2023

cc: K. Scott Wester, President and Chief Executive Officer, MHS
Alberto Garcia, Chief Nursing Officer, MHM
Todra Anderson-Rhodes, Chief Medical Officer, MHM
Cheryl Boucher, Vice President Revenue Cycle Management, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: July 12, 2023

From: Mario Salceda-Cruz, Chief Operating Officer, MPG
Esther Surujon, Chief Financial Officer, MPG

Subject: **Action Plan:** Compliance Audit of High Risk Obstetrics Evaluation and Management Services for Memorial Physician Group Professional Coding and Billing

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Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that MPG Business Office correct and rebill or refund accounts as appropriate.	Refunds were not due as there were no overpayments to date. Any ICD10 codes not dropped by the provider will be reviewed and resubmitted if appropriate.	8/15/23
We recommend that the Director of Billing and Compliance reeducate providers on medical record documentation, coding, and billing to support medical necessity and services billed, as MPG Business Office does not code E/M or ICD-10 codes.	This was completed prior to this audit by the Coding manager and auditor. We will contact Dr. DeSantis and determine if a third session is required.	8/15/23
We recommend continued training for the providers on documenting and reporting discharge and ED services appropriately.	We will update the providers on the importance of documenting "time spent" when providing discharges to our patients.	8/30/23

cc: K. Scott Wester, President and Chief Executive Officer, MHS

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To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS

Date: September 8, 2023

From: Mario Salceda-Cruz, Chief Operating Officer, MPG MSC DS
Esther Surujon, Chief Financial Officer, MPG ES

Subject: **Action Plan:** Compliance Audit of High Risk OB Procedures for Memorial Physician Group Professional Coding and Billing

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Attached is our Action Plan, which identifies the steps which will be taken to address the recommendations made in the above referenced audit.

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that Memorial Physician Group (MPG) Business Office correct and rebill or refund accounts as appropriate.	The total refund related to affected claims for Urinalysis was $53.25 and for NST was $127.40. These refunds have already been processed. The total dollar impact was ~$180	Completed.
We recommend providers be reeducated on medical record documentation, coding, and billing of routine and non-routine global OB care services.	For UA, this is not an education issue. The physicians do not drop UA charges. The charge drops when the test is resulted. We are creating an Epic edit to hold the urinalysis test for payors that have global packages. We are currently reviewing all the contracts to confirm which plans include the urinalysis in the global package. In the interim, the edit will hold all UAs for OB. For NST, we will provide refresher education to the providers for medical documentation supporting NSTs.	10/15/2023

We recommend MPG Business Office develop, implement, and monitor for compliance with documentation, coding, and billing of urinalysis and NST services.	We will add these services to our QA process.	Ongoing Monthly
We recommend MPG Business Office coordinate with Information Technology (IT) to update Epic with the services included in the global OB care package.	This recommendation was the business office's plan to mitigate this risk, that we shared with the Compliance department. We are already creating an edit to hold UA and review for any other items that are auto billed and in a global package.	Completed
We recommend MPG Business Office initiate a retrospective review of urinalysis and NST services to identify charge capture errors and correct and rebill if appropriate.	This is currently in process and total refund is estimated < $ 1,500. This is including UA and NSTs. Final total and refunds will be processed by Oct. 15.	10/30/2023
We recommend that MPG Administration ensure that Open Payment covered recipients are registered and updated in the Open Payments system and CMS Identity Management (IDM) and to monitor the data on their behalf.	This is part of clinical operations and will continue to be monitored on and ongoing basis. New file is published next CY.	Next Review period 4/1-5/15/2024

cc: K. Scott Wester, President and Chief Executive Officer, MHS