



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

**DATE:** October 31, 2024

**TO:** Shane Strum, Interim President and Chief Executive Officer, MHS

**SUBJECT:** **AUDIT AND COMPLIANCE – SECOND QUARTERLY REPORT FISCAL YEAR 2025**

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Attached is a copy of the second quarterly report of fiscal year 2025 summarizing the activities of the Internal Audit and Compliance Department from August 1, 2024, through October 31, 2024, for your records.

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

A handwritten signature in black ink that reads 'Denise D. DiCesare'.

Denise (Denny) DiCesare  
Chief Compliance and Internal Audit Officer

cc: Dave Smith, Executive Vice President and Chief Financial Officer, MHS  
Aharon Sareli, Executive Vice President and Chief Medical Officer, MHS  
Holly Neville, Chief Physician and Associate Chief Medical Officer, MHS  
Irfan Mirza, Vice President of Finance, MHS

## **I. WRITTEN STANDARDS AND PROCEDURES**

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

Reviewed:

- Records Management,
- Health Information Management and Coding Policies and Procedures, and
- Reporting of Potential Issues or Areas of Noncompliance.

Revised:

- Standards of Conduct,
- Compliance Program Training, and
- Laboratory Services.

## **II. COMPLIANCE OFFICER**

The Compliance Officer attended the following meetings during the quarter:

- Florida Compliance and Privacy Consortium: One Session,
- CMS National Provider Compliance Conference,
- AHA Navigating the Health Care Cyber Security Storm: Strategies for Resilience and Risk Reduction,
- FHA Statewide Medicaid Management Care Insights from Florida Community Care, and
- Protiviti Innovating Audit.

## **III. TRAINING AND EDUCATION**

The following compliance training was provided during the quarter:

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

## **IV. OPEN LINES OF COMMUNICATION**

### **A. Hotline Calls**

During the quarter, 67 calls, none of which were callbacks, were placed to the System's Compliance Hotline covering 57 new topics and no old topics. Six topics were compliance allegations (six calls). Two topics were HIPAA Privacy allegations (two calls). Two topics were Patient Safety allegations (two calls). One topic was Quality of Care/Service allegation (one call). Two topics were Workplace Safety allegations (two calls). All of the calls were investigated and one of the compliance allegations was substantiated.

Finally, two topics were informational (two calls), four topics were uncompleted calls (four calls), and 38 new topics (48 calls) were employee-management relations issues. The employee-management relations issues have been forwarded to the Employee Relations and Human Resources Departments.

## **V. ENFORCEMENT & DISCIPLINE**

### **A. Sanctions Checks**

Sanction checks were conducted of employees, physicians, vendors, volunteers, and students. One referring provider was sanctioned during the quarter. Accounts Receivable Management was notified so that appropriate action can be taken.

## **B. Conflicts of Interest**

The Calendar Year (CY) 2024 Conflicts of Interest Questionnaire cumulative employee completion rate is 97.8% in which 16,966 of the 17,334 employees completed their questionnaire. There were 241 reports of possible or potential conflict of interest that were researched.

On October 10, 2024, the Conflicts of Interest Subcommittee members met and were trained on the conflicts review process and risk scoring assessment tool. There were 11 disclosed conflicts in queue to be evaluated and risk rated.

## **VI. RISK ASSESSMENT, MONITORING & AUDITING**

### **VII. RESPONSE & PREVENTION**

#### **A. Internal Audit Recurring Quarterly Reports**

##### **South Broward Hospital District Construction Projects**

Eleven payment vouchers for eight 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**

Ten 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 and Government Affairs Expenses**

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

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

#### **B. Internal Audits**

##### **Internal Audit of Information Technology Contracts**

###### **Background**

Information Technology (IT) plays an integral part in supporting Memorial Healthcare System's (MHS) business operations. MHS has several IT contracts with vendors to provide products and services such as software licenses and maintenance, cloud services, and leases. The MHS "IT Contract Review and Approval" policy provides guidance for IT personnel participating in the review and approval process of IT contracts execution.

We reviewed relevant MHS policies and met with representatives from the Legal, Risk and Privacy Department (Legal) to obtain an understanding of the IT contract process. We evaluated compliance with policies and procedures. We selected a sample of 30 IT contracts that were active as of June 14, 2024, from MediTract, MHS's legacy contract management system. We reviewed the contract review and approval process; contract documents with evidence of contract negotiations of contract terms and conditions; and reviewed the contract routing and approval process.

###### **Observations**

Twenty-nine contracts did not have significant negotiation issues. One contract with Epic Systems Corporation (Epic) provided negotiation issues regarding MHS proposed addendums. Epic was not willing to accept the proposed addendums and renegotiate the core contract as part of the Payor

Platform Agreement. Since Epic dominates the market, they tend to have the upper hand during contract negotiations. However, Epic was willing to make limited modifications in certain situations. MHS Legal has adequate controls to mitigate risks and negotiate terms in the best interest of the organization. All 30 contracts did not contain language regarding vendors or consultants using MHS email to discuss MHS business while providing contracted services. Forms such as the Business Associate Agreement (BAA) and Privacy and Data Security Certification are incorporated into the contract process to ensure the vendor understands their duty to safeguard MHS' privacy and data. Ten of 30 MediTract contract cover sheets did not accurately reflect the contract value. Those contracts had documented values of \$0.00 or \$0.01 when the actual contract amount was significantly higher. However, with the transition to Workday to manage current contracts, the contract value field is required to be completed with the actual contract amount by the contract originator. Twenty contracts cover sheets accurately reflected the contract value. All contracts were reviewed by Supply Chain Management (SCM), Finance, and Legal Departments. All contracts contained the approved Legal stamp and were signed and dated by an appropriate MHS executive and the vendor. The MHS Administrative signatures for all contracts were within the authorized approval limits.

### **Recommendations**

None.

The results of the audit were communicated to all MHS attorneys who assisted us during the audit. Since there were no findings or recommendations in this audit, an action plan was not required.

### **C. Compliance Audits**

#### **Compliance Audit of the 340B Program at Memorial Healthcare System External Contract Pharmacies - FY 2025 Second 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 health care organizations/covered entities at significantly reduced prices. To participate in the 340B Program, eligible organizations must register and be enrolled with the 340B Program and comply with all the requirements, that includes maintaining an up-to-date 340B database; recertifying eligibility every year; and preventing 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 340B Program requirements may be liable to the manufacturers for refunds of the discounts obtained. To be eligible to receive 340B-purchased drugs, patients (1) must have an established relationship with the covered entity such that the entity maintains records of the individual's care; and (2) must receive health care services from a health care professional employed by the covered entity or under contract or other arrangement with the covered entity. An individual may receive a 340B drug in connection with treatment rendered outside the covered entity as part of continuum of care through a referral, consultation or follow-up care. The only exception is patients of state-operated or -funded acquired immunodeficiency syndrome (AIDS) drug purchasing assistance programs.

HRSA has developed guidelines to allow 340B covered entities to contract with a pharmacy or pharmacies to provide services to the covered entity's patients, including dispensing the entity-owned 340B medications. In order to engage in contract pharmacy services, the entity and pharmacy(ies) must have a written contract that aligns with the compliance elements listed in HRSA

guidance; must register for the 340B Program and be listed as active on the 340B Office of Pharmacy Affairs (OPAIS) prior to dispensing 340B drugs on a covered entity's behalf. Covered entities are responsible for ensuring compliance of their contract pharmacy arrangement(s) with all 340B Program requirements. The covered entity and contract pharmacy must establish and maintain a tracking system to prevent diversion of drugs to individuals who are not patients of the covered entity.

Memorial Healthcare System (MHS) participates in the 340B Program. There are seven MHS owned contract pharmacies. In addition, starting January 2023, MHS has opted to expand contract pharmacy services to multiple pharmacy chains or External Contract Pharmacies in order to extend the delivery of patient care services. In order to manage the 340B Program, MHS uses split-billing software from Verity solutions Group (Verity) to manage all external contract pharmacy arrangements. Verity helps each covered entity track and separate (“split”) the 340B eligible dispensations from non 340B dispensations which ultimately determine medications that may be purchased at the 340B price. An accumulation is received for replenishment each time a medication is dispensed to a 340B eligible patient. A 340B replenishment order is placed when the accumulations reach a full package size. Based on current policies and contractual agreements with external contract pharmacies, 340B replenishment orders are not placed for non-covered items and certain generic medications. The purpose of this audit was to determine if MHS external contract pharmacies are in compliance with the HRSA 340B Program requirements.

### **Observations**

All 120 340B external contract pharmacy claims submitted met the 340B eligibility requirements. We were unable to locate the original or copy of prescriptions in Epic, MHS electronic health record system (EHRs) for five of 120 claims. One claim was prescribed by a non-credentialed provider as a continuum of care to a prior MHS encounter. Four claims were prescribed by MHS credentialed providers at the prescribers’ office or clinic. According to 340B management, one of the four claims accumulated as a 340B eligible dispensation by Verity was a generic medication that is not replenished per the specific external pharmacy contract. The remaining three qualified for 340B eligibility by referral capture. Also, the hard copies for these five claims were obtained by the 340B management from the external pharmacies and provided for this audit as requested.

### **Recommendations**

None.

Dorinda Segovia, Vice President & Chief Pharmacy Officer, MHS and Scott Davis, Vice President, Reimbursement and Revenue Integrity, Corporate Finance, MHS agreed with this audit and since there were no recommendations, an action plan was not required.

## **Compliance Audit of Documentation and Billing of Trauma Services at MRH**

### **Background**

Memorial Regional Hospital (MRH) is designated by the State of Florida as a Level One Trauma Center in Broward County. The American College of Surgeons (ACS) verified MRH as both an Adult and Pediatric Level Two Trauma Center. A trauma alert is called when Emergency Medical Services (EMS) notifies a trauma center that they are enroute with a patient meeting trauma alert criteria based on the Florida Administrative Code (F.A.C.) Rule 64J-2 Adult/Pediatric Trauma Scorecard Methodologies. The Broward County Uniform Trauma Transport Protocol uses this scorecard to further classify patients into EMS Level One or EMS Level Two trauma alert

activation. Centers for Medicare and Medicaid Services (CMS) allows only trauma centers designated by the state or verified by ACS to bill for trauma activation. Emergency Department (ED) charges for the level of service (LOS) utilized during the trauma encounter use the Facility Charge Calculator (FCC) to quantify the points accumulated for the intensity of patient care and resources utilized. Under the National Uniform Billing Committee (NUBC) guidelines, to bill for trauma activation with a pre-arrival notification from EMS, use revenue code 068x for trauma alert activation, Admission Type 05 for the Trauma Center location, Healthcare Common Procedure Coding System (HCPCS) code G0390 for the trauma team activation, and Common Procedural Terminology (CPT) code 99291 to report at least 30 minutes of hospital critical care services. Hospitals providing less than 30 minutes of critical care report revenue code 068x without G0390 to allow for the charges to be included in the hospital's cost report and report CPT code 99285 or lower for the ED charges. As a Level One Trauma Center, MRH must use revenue code 0681 regardless of the level of trauma activation.

### **Observations**

We noted all 30 accounts reviewed had EMS Run Reports that included the pre-hospital trauma alert activation called prior to the patient's arrival, the documented trauma alert level, the date and time of the trauma alert, the time of the patient's arrival, time of the trauma team's arrival, the trauma alert criteria met, the pre-hospital transport team, mechanism of injury, the primary survey assessments and interventions, and documentation supporting medical necessity for trauma alert activation.

We noted that all seven EMS Level One trauma alert activations appropriately triggered the FCC points to capture the criterion for the ED Trauma activated by the patient's admission. Four of the seven Level One Trauma accounts had documentation supporting the correct LOS, CPT code for at least 30 minutes of critical care, and trauma activation revenue code 0681 with HCPCS code G0390. Two accounts had the correct LOS, but critical care time was less than 30 minutes. One of those accounts reported the correct CPT code but did not include the revenue code 0681 for trauma activation. The other account reported the CPT code for critical care time at least 30 minutes and revenue code 0681 with G0390 but should have reported a lower CPT code and revenue code 0681 without G0390. One of the seven accounts had critical care time of at least 30 minutes but missed reporting revenue code 0681 with G0390.

Of the 23 accounts with EMS Level Two trauma alert activations, the FCC ED trauma points were appropriately triggered and accumulated for two accounts, and seven accounts had accumulated enough points to meet Trauma LOS, Level seven. On the remaining 14 accounts, a manual calculated FCC score noted that it should have also reported Trauma LOS, Level seven. All 23 accounts provided critical care services for at least 30 minutes and should have billed CPT 99291 with revenue code 0681 and G0390. However, 13 accounts reported lower-level ED CPT codes which affected reimbursement. One account had the correct ED CPT code because Critical Care LOS is reported with the same CPT code 99291 as Trauma LOS.

### **Recommendations**

We recommended Accounts Receivable Management (ARM) correct the charges for the accounts with the incorrectly reported procedure codes and revenue code, if appropriate. We recommended Trauma management update the critical care time definition in the trauma policy, and the processes used to review trauma cases to meet CMS guidelines. We recommended Trauma management enhance the process of reviewing trauma cases and increase area of focus to include trauma

admissions coming from the ED and audit the critical care time to ensure compliance with CMS guidelines for trauma activation billing. We recommended Trauma management, Corporate Finance, and Epic ASAP team collaborate to review how critical and trauma levels of service are currently documented in Epic and research the ability to capture the time that the trauma team spends providing critical care. We recommended Trauma leadership conduct monthly audits on Trauma patients for accuracy of billing.

Stephen Demers, Interim Chief Executive Officer, MRH, and Walter Bussell Chief Financial Officer, MRH, agreed with the audit findings and recommendations, and have provided an action plan.

## **Compliance Audit of Documentation and Billing of Emergency Medical Treatment and Labor Act at MHP**

### **Background**

The Emergency Medical Treatment and Labor Act (EMTALA) was enacted by Congress to ensure public access to emergency services regardless of the patient's ability to pay. The law details three main obligations necessary to comply with EMTALA. These include providing a medical screening examination (MSE) when a request is made for examination or for the treatment of an emergency medical condition (EMC), providing stabilizing treatment and lastly, if the hospital is not equipped to stabilize a patient within its capacity, or if the patient requests, implementing an appropriate transfer. Violations of EMTALA can result in large fines, and possible termination of the Medicare provider agreement for the facility involved.

Memorial Hospital Pembroke (MHP) has a dedicated emergency department (ED) that caters mostly to adult individuals seeking emergency services. The purpose of this audit was to determine if MHP is in compliance with the EMTALA requirements regarding policies and procedures, signage, triage, registration, MSE, stabilizing treatment, transfers in and out, and documentation.

### **Observations**

We observed that the EMTALA requirements were met on adopting policies and procedures that adhere to EMTALA, using appropriate signage, and maintaining appropriate transfer logs and physicians on-call lists. All 30 accounts reviewed had complete documentation of triage including timely MSE and stabilizing treatment provided. Out of 30 accounts, we noted 16 were transferred out in stable condition, 12 were admitted as inpatient, one was discharged stable, and one was discharged against medical advice (AMA). We noted an opportunity for improvement on the completion of the transfer forms in seven out of the 16 accounts for patients transferred. A review of the documentation in Epic provided the supporting documentation for the transfers and thus, did not result in a violation of EMTALA requirements. We noted that for the one patient that was discharged AMA, the documentation showed that the patient had a timely MSE, was provided stabilizing treatment and admission was advised by the medical provider. This was not a violation of EMTALA as the patient was stable on discharge and had appropriately signed the refusal of treatment form. Additionally, we noted in four out of 30 accounts, it took more than 60 minutes from the time of patient arrival to the ED to the time of physician first contact. These were not violations of EMTALA as we noted that the qualified medical personnel (QMP) attended to the patients immediately on arrival. As per requirements, MSE and treatment should not be delayed for registration. On three out of 30 accounts, we noted that the time stamps when registration was completed were done before the physician had seen the patient. These were not violations of EMTALA since the ED staff had attended to the patients, immediately on arrival and thus, there

was no delay in treatment. However, there was an opportunity for improvement because the standard procedure for registering patients was not followed.

### **Recommendations**

We recommended ED leadership conduct regular reviews to monitor for completeness of the written patient transfer form. We recommended Patient Financial Services (PFS) management reeducate the staff on the standard procedure of completing the registration in ED. We recommended PFS management perform regular audits to review that the correct process is being followed for registration.

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 Documentation and Billing of the Intravenous Hydration in the Emergency Department at MHP**

#### **Background**

Current Procedural Terminology (CPT) Code 96360 is reported for the initial 31 minutes to one hour of intravenous (IV) infusion hydration and CPT code 96361 is each additional hour of IV infusion hydration. Infusion is the administration of fluids and/or drugs through the vein given over a period of time for diagnostic or therapeutic purposes. An IV push/injection occurs when the drug is given 15 minutes or less and requires that the healthcare professional is continuously present to observe the patient during drug administration. Medicare pays for hydration services when documentation indicates that the service is medically reasonable and necessary. When reporting facility claims, the codes for infusions and injections should follow a hierarchy wherein chemotherapy services are primary over therapeutic, prophylactic, or diagnostic services, which are primary over hydration with the infusion primary to IV push and injection the last. The start and stop times of hydration services should be documented to select the appropriate administration codes when multiple drugs are infused at one encounter. A compliance audit performed in January 2021 of the IV hydration services in the Memorial Hospital Pembroke (MHP) Emergency Department (ED) identified the prompts in Epic that described the time requirements were incorrect and accounts with less than 31 minutes were billed with CPT 96390. The action plan to correct the prompt description was completed in June 2021. In April 2024, Memorial Healthcare System (MHS) Corporate Finance and Epic Information Technology (IT) Team developed a new Epic Assisted Infusion Charging (AIC) tool in the ED designed to calculate the quantity in units of the administered medication infusion charges to assist nurses to post IV charges for patients discharged from the ED. The purpose of this audit was to determine if documentation supported medical necessity for hydration services and determine the accuracy of coding, charging, and billing of IV hydration services in the ED at MHP.

#### **Observations**

All 46 accounts with 115 medication administration reviewed had a provider order, medication administration record (MAR) documentation, documentation of the start and stop times of the IV hydration and infusions, and diagnosis supporting medical necessity. We noted that in four claims, the number of units charged for the injection and hydration services were duplicated affecting the reimbursement on three of the four claims. On the remaining one claim, Medicare appropriately did not pay the affected CPT code. We noted that in one claim, the IV hydration service was administered with the medication infusion and should not have been reported separately on the claim as per Medicare guidelines. We noted one medication injection was not reported on the claim



affecting reimbursement. Finally, we noted one account had a duplicated charge and missed a CPT code on the claim but neither affected reimbursement because the account was billed using an inpatient diagnosis related group (DRG). This resulted in an error rate of 5.2% with an overpayment of \$ 394.60 and an underpayment of \$ 34.27 We were told that the nurses were trained to check the IV hydration prompts generated by the Epic AIC tool. It is believed that the duplicate charges occurred when the prompt appeared again as if it was not already checked.

### **Recommendations**

We recommended Accounts Receivable Management (ARM) review and correct the charges for the accounts with the duplicate or missed charges, when necessary. We recommended Corporate Finance develop a work queue and review the ED accounts from April 2024 for potential duplicate charges and correct the entries manually, when necessary. We recommended ED leadership reeducate the nurses on appropriate posting of IV charges in Epic. We recommended ED leadership do regular audits to monitor charges for accuracy. We recommended Corporate Finance continue to review all primary and secondary IV hydration, infusions and injection charges anytime new Epic features are implemented to ensure charges are accurate.

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 Documentation and Billing of the Mammogram Procedures in the Women's Imaging Center at MRHS**

#### **Background**

Breast cancer is the second most common cancer and the second leading cause of cancer-related death among women in the United States. Mammography (Mammo) is a low-dose radiologic imaging procedure used to detect breast cancer and other breast diseases. Congress enacted the Mammo Quality Standard Act (MQSA) on October 27, 1992. The Food and Drug Administration (FDA) ensures all mammo facilities comply with the MQSA certification. The National Coverage Determination (NCD) for mammo outlines the description, indications, and limitations of coverage for both screening and diagnostic mammo.

In October 2021, Memorial Healthcare System (MHS), entered into a partnership with Solis Mammography (Solis), to expand and enhance access to women's breast health services. Through this arrangement, MHS and Solis aim to deliver high-quality breast imaging services that prioritize enhanced care coordination, improved access to breast health, and timely availability of mammo services. According to the technical imaging service agreement, Solis provides mammo services, equipment, equipment maintenance, center improvements (with written consent from MHS), operating supplies and materials. MHS employs and directly supervises its own staff, while Solis is responsible for managing the staff. MHS compensates Solis a predetermined amount for each applicable Current Procedural Terminology (CPT) code for services rendered each month for each facility. The total monthly compensation is calculated after deducting applicable fees for services provided by MHS, such as billing fees, space fees, management fees, staff compensation, and other operational expenses related to the department. The MHS Compliance and Internal Audit Department selected screening and diagnostic mammo procedures, along with breast ultrasound when ordered in conjunction with mammo and rendered at the same dates of service for review at Memorial Regional Hospital South (MRHS). The purpose of this audit was to determine if documentation supported medical necessity for mammo procedures performed and determine the accuracy of coding, charging, and billing of the Women's Imaging Center at MRHS.

## **Observations**

We reviewed 30 dates of services for screening and diagnostic mammo procedures, along with 21 breast ultrasounds ordered in conjunction with the mammo. All 30 dates of services had documentation to support medical necessity. All 30 patient dates of services had provider orders entered in Epic or written prescription orders scanned to Epic by Patient Financial Services (PFS). One of 30 dates of services had a prescription order dated in 2025, making it invalid until that date. Subsequent to this finding Accounts Receivable Management (ARM) refunded that date of service. The risk is low with an error rate of 3% as only one of 30 dates of services had an invalid prescription. All 30 dates of services had an imaging interpretation report documented by radiologists and computer aided diagnostic evaluation (CAD). Charges for all procedures were entered by the department staff. The appropriate diagnoses were noted on all dates of services. All 30 dates of services had the appropriate primary CPT code in conjunction with the additional CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes charged and billed. All 21 breast ultrasound CPT codes were appropriately billed on the same claim as the mammos. We noted the ordering providers' information were reported on the claim as required. Twenty-eight of 30 dates of services were reimbursed, while two dates of service were denied appropriately as the original ordering provider was not enrolled with Medicaid. These mammos were ordered by a resident, requiring an authorizing provider and considered an outlier finding for this audit. We noted that the orders for the two dates of service were cancelled then reordered on the day the procedure was rendered. One mammogram was reordered by an authorizing Medicaid provider. The other was reordered and updated from a standard order to more detailed images by a different Medicaid provider. This update was made to ensure the appropriateness of the imaging, as the initial mammogram result was abnormal. Subsequent to this finding ARM updated the information and rebilled the two dates of service.

## **Recommendations**

We recommended that the PFS management reeducate the PFS team to ensure all written prescriptions contain the required elements including an accurate order date.

Phil A. Wright, II, Chief Executive Officer, MRHS, and David Webb, Chief Financial Officer, MRHS, agreed with the findings and recommendation and have provided an action plan.

## **Compliance Audit of Evaluation and Management Services for Memorial Primary Care Professional Coding and Billing**

### **Background**

Memorial Primary Care (MPC) has a highly skilled team of healthcare professionals dedicated to providing services from prevention, wellness, and treatments for common and chronic illnesses. A medically reasonable and necessary evaluation and management (E/M) visit includes documentation of 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, or telehealth. Billing also requires selection of the International Classification of Diseases Tenth Revision, Clinical Modification (ICD-10-CM) codes to report medical diagnoses. Advanced Practice Registered Nurses (APRNs) can report services independently or as a shared/split visit in an institutional setting when services are performed in part by a physician. 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 indicate that either audio-video or audio only was used and appended using a modifier. The Physician Payments Sunshine Act is a federally mandated disclosure program that requires medical devices and drug manufacturers and distributors to report payments to physicians, APRNs, and teaching hospitals and are accessible through the Open Payments Program. The purpose of this audit was to determine whether documentation and coding complied with the Medicare requirements when billing for primary care E/M services.

### **Observations**

We reviewed 258 E/M services accounts for 26 physicians and five APRNs. Of the 258 accounts reviewed, we noted that for 231 accounts the CPT codes were appropriate for the services documented. In the remaining 27 accounts, one account was coded two or more E/M service levels lower than the supported documentation, 16 accounts had documentation that supported a different CPT code, eight of which were appropriately denied payment, and ten accounts had documentation that was insufficient to support billing for services, two of which were appropriately denied payment and only one was billed to a program payor. This resulted in an 11% error rate with an estimated overpayment amount of \$1,753.58 and underpayment amount of \$1,012.01. The documentation for 45 accounts supported billing for a different place of service of which reimbursement was not affected. There were 100 accounts that had appropriately reported the modifiers and reimbursement in the remaining 16 accounts was not affected since the modifiers were informational. Twenty-six accounts had ICD-10-CM codes that were supported by documented medical necessity. In the remaining accounts, we noted that medical record documentation supported additional or different ICD-10-CM codes. However, reimbursement was not affected. We learned that 24 accounts were not paid for various reasons and were reprocessed, corrected, and paid or are expected to be paid except for one account where the time for refiling has expired. We collected and analyzed the CMS Open Payments data for each of the physicians and APRNs in this audit and there were no significant findings.

### **Recommendations**

We recommended that Memorial Physician Group (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.

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.

### **Compliance Audit of Memorial Cancer Institute Hematology and Oncology Evaluation and Management Services for MPG Professional Coding and Billing**

#### **Background**

Memorial Cancer Institute (MCI) has a multidisciplinary team that offers comprehensive treatments for complex oncology conditions. Physician services are the professional services such as diagnosis, therapy, surgery, consultation, and care plan oversight. A medically reasonable and necessary evaluation and management (E/M) visit includes documentation of 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) and Physician Assistants (PAs) 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. Telehealth billing codes are based on documentation, the telecommunications used, and an appropriate modifier.

### **Observations**

Of the 297 E/M services reviewed, 220 were rendered by physicians and 77 were rendered by APRNs and PAs. We noted that for 266 accounts, the E/M CPT codes were appropriate for the services provided. The documentation for 31 accounts supported a different E/M CPT code and five accounts were coded at two or more E/M service levels higher than the documentation supported resulting in a 10.5% error rate. Three accounts were under paid by \$260.67 and five accounts were overpaid by \$248.92, two of which were program payors. Fifty-two of the 54 teaching physician services accounts met the CMS teaching physician guidelines. Six of the 12 telehealth service accounts met CMS telehealth billing requirements but six used an incorrect place of service code. Twenty-seven of the 29 incident-to visits met the CMS guidelines, and all 33 shared/split visits met the CMS guidelines. The appropriate modifiers were applied to 283 of 297 accounts and in the remaining accounts, reimbursement was not affected because the modifiers were informational in nature. There were 126 accounts that the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes were appropriate for the documented medical necessity. The remaining accounts had diagnosis documentation that supported additional or different ICD-10-CM codes. We learned that 15 accounts were not paid for various reasons, however, four were appealed and pending payment, six were soft denials that will be reprocessed, two were reprocessed to be corrected by the payer, and three were not true denials, and the statuses were updated, and no additional payment is due.

### **Recommendations**

We recommended that MPG Business Office correct and rebill or refund accounts as appropriate. We recommended that the Medical Director and the Administrative Director of Oncology coordinate with the Director of Billing and Compliance to reeducate the providers on CMS documentation guidelines, telehealth documentation and coding requirements, and the MPG Copy and Paste Policy.

Patrick Brillantes, Senior Vice President-Service Lines, MHS, Meredith B. Feinberg, Vice President-Oncology Service, MPG and Esther Surujon, Chief Financial Officer, MPG agreed with the findings and recommendations and have provided a detailed action plan.

### **Follow Up Compliance Audit of the Documentation and Billing of Strapping, Unna Boot in the Wound Care Center at MHP**

Unna boot is a wound care dressing indicated for the following conditions: to treat venous vascular insufficiency; for the treatment of ulcers with and without inflammation of the lower extremities which are caused by increased venous pressure, venous insufficiency or capillary dysfunction; and for the management of sprains, strains, dislocations and minor fractures. Medicare covers Strapping, Unna boot under the Local Coverage Determination (LCD) "Wound care" which is contingent on the documentation that the wound is improving in response to the wound care being provided. At a minimum, the documentation must include the current wound volume; presence or

absence of obvious signs of infection; presence or absence of necrotic, devitalized, or non-viable tissue; and other material in the wound that is expected to inhibit healing or promote adjacent tissue breakdown. The medical record documentation must have a plan of care containing treatment goals and physician follow-up.

An audit was performed in September 2022 of the Memorial Center for Wound Healing and Hyperbaric Oxygen Therapy (Wound Care Center) at Memorial Hospital Pembroke (MHP) in response to a Comparative Billing Report (CBR), received from First Coast Service Option (FCSO) citing an aberrancy for Current Procedural Terminology (CPT) code 29580, Strapping, Unna Boot. The audit identified errors related to the documentation not supporting the wound care services billed, coding of the wound care procedure performed, wound care service not meeting medical necessity, and additional wound care procedures that should not have been reported separately. The action plan items were to be completed by October 31, 2022. The purpose of this audit was to determine if the action plan recommendations from the previous compliance audit have been implemented, medical record documentation is complete, Strapping; Unna boot procedures are coded correctly, and the wound care LCD is followed, and to assess the effectiveness of the corrective actions in the Wound Care Center at Memorial Hospital Pembroke.

### **Observations**

All 15 patient accounts reviewed had documentation of the wound, including the description, size and location, and evidence of wound improvement, thus meeting medical necessity for the wound care procedure. All 15 accounts had diagnoses that met indication for a compression dressing. All accounts had provider orders and appropriate documentation of the wound care procedures. All 15 accounts were coded, charged, and billed correctly. All accounts were paid except for two Medicare Advantage (MA) accounts, which were appropriately denied, because one claim did not have authorization prior to the date of service and the other claim had an incomplete or invalid procedure code.

Review of the previous action plan responses were fulfilled by the Wound Care Management on reeducation of the staff and providers, ongoing timely and regular audits for appropriateness and completion of documentation, and by Accounts Receivable Management on the correction of the identified accounts with errors. We noted that the action item to send FCSO notification of the incorrect CPT code selection for wound care that was not the Unna boot may not have been received. Subsequently, another letter with the current audit findings of no coding errors was sent.

### **Recommendations**

None.

Felicia Turnley, Chief Executive Officer, MHP and Patrick Connor, Chief Financial Officer, MHP, agreed with the findings of this audit. As there were no recommendations, an action plan was not necessary.

### **Follow Up Compliance Audit of the Medicare Outpatient Observation Notice at MHM**

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) explains to the beneficiaries that they are outpatients receiving observation services, rather than inpatients and alerts the patients about their potential financial responsibility related to observation

services. It can be provided at any time within 36 hours after observation services begin. The observation services start time begins when physician's order is documented in the patient's medical record.

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. The beneficiary or representative must sign and date the MOON to demonstrate understanding and receipt of the notice and a paper copy of the MOON must be provided at the time the notice is delivered. If the beneficiary refuses to sign the MOON, and there is no representative to sign, 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. If a representative is not physically present, the MOON must be delivered telephonically and must follow the Medicare guidelines to ensure delivery and receipt. 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 (PFS) Department staff at Memorial Hospital Miramar (MHM) provides the MOON to beneficiaries after a physician's order for observation service is documented in the medical record and the account is updated by admitting department to reflect the status when there is sufficient time prior to transfer to the floor. However, the Case Management Department ensures the MOON is delivered to all Medicare and Medicare Advantage beneficiaries. The previous audit, which was completed in September 2023, noted the Medicare requirements for providing the MOON were not met in 22 of 30 accounts, and the action plan recommendations were assigned to both departments. The purpose of this follow-up audit was to determine if MHM re-educated staff regarding the requirements for providing the MOON according to Medicare guidelines, ensured patients received the MOON prior to transfer to the floor when time permitted, and ensured there is a process to complete and update the MOON as necessary.

### **Observations**

According to PFS Management, ongoing PFS individual and team education is provided on the correct completion of the MOON. The Case Management team reviews all Medicare and Medicare advantage observation admissions daily to confirm that the MOON was provided, and audits of selected outpatient accounts are performed to ensure compliance. All 15 accounts had observation orders with the observation services start time entered by the provider. The completed MOONs were uploaded to the Media tab of the medical records for all 15 accounts. All accounts had the required documentation. Fourteen accounts were delivered within the set guidelines, a significant improvement from previous audit. For one account, the MOON was provided over 36 hours after the observation time began. The error rate is low because the one MOON was ultimately delivered to the patient, though it was late due to insufficient time before the patient was transferred to another unit. Delivering the completed MOON to the beneficiaries is a required standard under the Conditions of Participation in the Medicare and Medicaid programs and a quality and safety measure that is not quantified using reimbursement.

### **Recommendations**

We recommended the Case Management Department continue with the current process of daily

review and daily audits of selected Medicare and Medicare Advantage accounts to ensure continuity of compliance with MOON guidelines and 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.

**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.

	PO#6007559 Interventional Radiology Turner Construction Co. #401622 MHS	PO#6007465 Urgent Care Center Miami Gardens Gerrits Construction Inc. #650322 MHS	PO#6007489 Central Sterile Processing Thornton Construction Co. Inc. #430122 MHW	PO#10049832 MOB II Third Floor Sports Medicine Thornton Construction Co. Inc. #00148 MHM	Family Birthplace PO#6007570 Turner Constuction Co., Inc. #400622 MRH
	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	\$ 1,826,577	\$ 1,929,942	\$ 1,620,971	\$ 2,321,339	\$ 43,850,159
Prior Change Orders					
Current Change Orders			(261,732)		
Prior Owner Purchase Orders	(401,108)	(179,731)			(9,703,000)
Current Owner Purchase Orders	205,923	2,027			2,506,043
Current Contract Sum to Date	\$ 1,631,392	\$ 1,752,237	\$ 1,359,239	\$ 2,321,339	\$ 36,653,202
Previous Payments	1,212,557	1,749,320	1,232,224	620,862	23,348,790
	8 325,758	14 2,917		2 253,871	18 1,274,585 19 930,212
Total Payments	1,538,316	1,752,237	1,232,224	874,734	25,553,587
Balance	\$ 93,076	\$ 0	\$ 127,015	\$ 1,446,606	\$ 11,099,615
Owner Purchased Materials					
Retainage	20,034		24,669	34,860	1,408,774
Payments	1,538,316	1,752,237	1,232,224	874,734	25,553,587
Work completed	\$ 1,558,350	\$ 1,752,237	\$ 1,256,894	\$ 909,594	\$ 26,962,361
Status	Active	Active	Active	Active	Active



	MOB II Second Floor Pediatric Fit Out Thornton Construction Co. Inc. #800122 MHM	MOB Women Center ANF Group, Inc. #450218 MHM	PO#6007171 Memorial Cancer Center Expansion DPR Construction #431019 MHW	PO#6007169 Hurricane Hardening Thornton Construction Co. #410121 MRHS	PO#6007692 MOB II 3rd Floor Time Share Fit Out Thornton Construction Co. #830922 MHM
	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	\$ 10,650,417	\$ 35,067,236	\$ 86,165,924	\$ 13,613,113	\$ 2,148,948
Prior Change Orders		(5,101,409)	(15,571,906)		
Current Change Orders					
Prior Owner Purchase Orders	(2,591,108)	(750,000)	(494,336)	(2,705,194)	(450,000)
Current Owner Purchase Orders	108,194			813,248	129,761
Current Contract Sum to Date	\$ 8,167,503	\$ 29,215,826	\$ 70,099,682	\$ 11,721,167	\$ 1,828,709
Previous Payments	7,479,269	27,791,202	64,858,649	11,346,741	1,484,797
			34 137,575		7 46,060
			35 209,935		
Total Payments	7,479,269	27,791,202	65,206,159	11,346,741	1,530,857
Balance	\$ 688,234	\$ 1,424,624	\$ 4,893,523	\$ 374,426	\$ 297,852
Owner Purchased Materials					
Retainage			101,027	154,846	
Payments	7,479,269	27,791,202	65,206,159	11,346,741	1,530,857
Work completed	\$ 7,479,269	\$ 27,791,202	\$ 65,307,186	\$ 11,501,587	\$ 1,530,857
Status	Active	Active	Active	Active	Active

	PO#6007446PS JDCH ER Room Finishes Engel Construction, Inc. New #460423 (Old#460120) JDCH	Memorial Cancer Institute ANF Group, Inc. #401820 MHS	PO#6007523 Emergency Department Trauma Center Turner Construction Company #400222 MRH	JDCH Vertical Expansion Robins & Morton Group #460117 JDCH
	Amount	Amount	Amount	Amount
Original Contract Sum	\$ 1,920,630	\$ 3,318,036	\$ 16,401,716	\$ 108,993,259
Prior Change Orders		(396,184)		
Current Change Orders			(173,000)	
Prior Owner Purchase Orders	(218,164)		(3,300,002)	(15,093,946)
Current Owner Purchase Orders	39,487	(113,525)	1,441,190	(19,979)
Current Contract Sum to Date	\$ 1,741,953	\$ 2,808,327	\$ 14,369,904	\$ 93,879,334
Previous Payments	742,894	2,808,328	7,498,049	87,772,918
		22 -	18 319,264 19 342,323	
Total Payments	742,894	2,808,328	8,159,636	87,772,918
Balance	\$ 999,059	\$ (0)	\$ 6,210,268	\$ 6,106,416
Owner Purchased Materials				
Retainage	39,100		285,880	
Payments	742,894	2,808,328	8,159,636	87,772,918
Work completed	\$ 781,993	\$ 2,808,328	\$ 8,445,517	\$ 87,772,918
Status	Active	Active	Active	Active

Memorial Healthcare System  
RFP and Competitive Quote Audits

RFPs	Current Phase - 2nd Quarter FY 2025	Audited Last Quarter	Audited Current Quarter	Exceptions
1 Joint Replacement RFP	Cancelled	Advertising & Mailing	Cancelled	None
2 Janitorial Services RFP	Ranking & Selection	Advertising & Mailing	Analysis	None
3 Rewards and Recognition RFP	Ranking & Selection	Design	Design	None
4 Contact Center Augmentation RFP	Ranking & Selection	Advertising & Mailing	Receipt	None
5 Parking Management Service	Pre Ranking	Design	Design	None
6 Employee Survey Tool	Selection	Oral Presentation	Selection	None
7 Clinical Engineering Computerized Maintenance Management System	Selection	Oral Presentation	Oral Presentation	None
8 Pest Control RFP	Analysis	New	Advertising/Mailing	None
9 EPIC On-Premise to Azure RFP	Selection	New	Receipt	None
10 Merchant Services Processor RFP	Selection	Oral Presentation	Selection	None

**Memorial Healthcare System  
RFP and Competitive Quote Audits**

<b>Completed Competitive Quotes</b>	<b>Amount \$</b>	<b>Exceptions</b>
1 Replacement Equipment for Douglas Road and Regional Datacenters for MHS	1,099,394	None
2 Three Year Licenses and Services Renewal of Patient Identification Solution for MHS	744,284	None
3 Airconditioning Repairs at Memorial Cardiovascular Institute	476,336	None
4 Five Year Service Agreement for Beds at JDCH	447,296	None
5 Laboratory Reagents Standing Order for MRH	407,910	None
6 Resurfacing of Parking Lot at MHP	369,574	None
7 Two Year Patient Beds Service Agreement at JDCH	346,825	None
8 Five Year Service Agreement for Radiology Equipment for MHS	328,980	None
9 Ablation Supplies for Electrophysiology Service Lines at MRH	295,600	None
10 Ultrasound Equipment for Radiology at MRH	255,334	None
11 Year Two of Three Year Sponsorship & Advertising Contract with the Florida Panthers Hockey Club for JDCH	250,000	None
12 Mobile Storage Systems for Mailroom and Receiving at MRHS	219,151	None
13 Audio Visual Equipment for Human Resources Education Center	208,607	None
14 Clinical Diagnostics Equipment Service Agreement for MHS	191,000	None
15 Replacement Equipment for Cardiovascular Institute at MRH	189,200	None
16 Active & Inactive User Archived Data Migration to Microsoft 365 for MHS	188,619	None
17 Architectural Fees for Memorial Cancer Institute Hallandale Expansion Project	183,945	None
18 Restoration Repairs to the Parking Garage at MhW	177,167	None
19 Window Cleaning Services for MRH	165,850	None
20 Agreement for Mobile Displays & I- 575 Highway Billboards for MHS	163,773	None
21 Agreement for Mobile Displays & I- 95 Highway Billboards for MHS	156,683	None
22 Water Purification System for MHP	139,220	None
23 Surgical Equipment Service Agreement for MRH	136,080	None
24 Clinical Diagnostics Equipment Service Agreement for MHW	133,920	None
25 Closet Remediation Project at MRHS	127,462	None
26 Consultant Agreement for Pre-Construction Services for Freestanding Emergency Department at Douglas Road	124,575	None
27 Equipment for Information Technology Closets at MRH	111,638	None
28 Service Line Alignment & Marketing Operations Infrastructure & Optimization Agreement for MHS	108,800	None
29 Architectural Fees for Medical Office Building at MRH	106,275	None
30 Patient Monitoring Equipment for MRH	103,474	None

**Memorial Healthcare System  
Investor Contact Log  
Fiscal Year 2025**

<b>Quarter: Ended</b>	<b>Contact:</b>	<b>Representing:</b>	<b>Discussion:</b>
July 31, 2024	Stephen Infranco	Standard & Poor's	Rating discusson
	Beth Wexler and Vanessa Chebli	Moody's	Rating discussion
October 31, 2024	Stephen Infranco	Standard & Poor's	Management change discussion.
	Beth Wexler	Moody's	Management change discussion.
January 31, 2025			
April 30, 2025			

**Memorial Healthcare System  
Non Audit Engagement Report  
Q2 FY 2025**

<b>Quarter Ended</b>	<b>RSM US LLP Engagement:</b>		
	For professional services rendered and expenses incurred in connection with implementing the GASB 96 Technical subscription based information technology arrangements accounting.	\$	3,402
Q2 FY2025	For professional services rendered and expenses incurred in connection with the preparation of Memorial Healthcare System 4960 analysis for the year ended April 30, 2024.	\$	15,750
	For professional services rendered and expenses incurred in connection with the preparation of Joe DiMaggio Children's Hospital Foundation Inc. and Memorial Foundation Inc. Form 990 tax returns for the year ended December 31, 2023.	\$	11,088
	Total	\$	30,240
Q2 FY2024	Total spend, provided for comparative purpose	\$	28,979

<b>Quarter Ended</b>	<b>Zomma Group LLP Engagement:</b>		
Q2 FY2025	For professional services rendered and expenses incurred in connection with Non Audit Engagements.	\$	-
Q2 FY2024	Total spend, provided for comparative purpose	\$	-



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**To:** Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS  
**Date:** November 6, 2024  
**From:** Aurelio Fernandez, Interim Chief Executive Officer, MRH *AF*  
 Walter Bussell, Chief Financial Officer, MRH *WBussell*  
**Subject:** **Action Plan: COMPLIANCE AUDIT OF THE DOCUMENTATION AND BILLING OF TRAUMA SERVICES 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 ARM review and correct the charges for the accounts with the incorrectly reported CPT and HCPCS codes, revenue code for trauma activation, if appropriate.	The Compliance Department confirmed with ARM the account corrections have been made.	November 2024
We recommend Trauma management include the definition for critical care time in the trauma policy and procedures for clarity and consistency.	Trauma management will review trauma center industry practices and develop guidelines for ED critical care time parameters for inclusion in the Trauma Department policy and procedures.	January 2025
We recommend Trauma management enhance the process of reviewing trauma cases and increase area of focus to include trauma admissions coming from the ED and audit the critical care time to ensure compliance with CMS guidelines for trauma activation billing.	Trauma management will utilize industry guidance and identify best practices to review cases and verify the accuracy of critical care time to ensure compliance with billing standards.	January 2025

<p>We recommend Trauma management; Corporate Finance, and Epic ASAP team collaborate to review how critical and trauma levels of service are currently documented in Epic and research the ability to capture the time that the trauma team spends providing critical care.</p>	<p>Trauma management will work with the respective MHS teams and conduct review of current process and establish parameters for capture and documentation of critical care time to support accurate billing.</p>	<p>January 2025</p>
<p>We recommend Trauma leadership conduct monthly audits on Trauma patients with focus on the MHS FCC scoring, charges for the trauma activation code G0390, and critical care time for accuracy of billing.</p>	<p>Trauma management will work with the revenue support team to conduct the recommended audits of trauma activation charging and critical care time documentation and billing accuracy.</p> <p>Trauma management and the revenue support team are reeducating the ARM nurse audit team regarding level of care charges and trauma activation fees.</p>	<p>Begin December 2024</p> <p>Ongoing</p>

cc: Shane Strum, Interim Chief Executive Officer, MHS





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

**Date:** December 12, 2024

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

*JET*  
*Patrick Connor*

**Subject:** Action Plan: COMPLIANCE AUDIT OF THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT 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 Emergency Department (ED) leadership conduct regular reviews to monitor for completeness of the written patient transfer form.	ER Clinical Manager review of Transfer Form for completeness prior to patient transfer. ER Quality to maintain ongoing audit of Transfer Form for 100% completion.	December 31, 2024
We recommend Patient Financial Services (PFS) management reeducate the staff on the standard procedure of completing the registration in ED.	PFS Leadership team will reeducate the team on registration processes for ER patients.	December 31, 2024
We recommend PFS management perform regular audits to review that the correct process is being followed for registration.	PFS Leadership team will complete monthly audits of patients treated in the ED to validate that registration is not completed until after physician first contact.	December 31, 2024

cc: Shane Strum, Interim Chief Executive Officer, MHS



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**To:** Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS  
**Date:** December 23, 2024  
**From:** Felicia Turnley, Chief Executive Officer, MHP *[Signature]*  
 Patrick Connor, Chief Financial Officer, MHP *[Signature]*  
**Subject:** **Action Plan: COMPLIANCE AUDIT OF THE DOCUMENTATION AND BILLING OF INTRAVENOUS HYDRATION IN THE EMERGENCY DEPARTMENT 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 Accounts Receivable Management review and correct the charges for the accounts with the duplicate or missed charges, when necessary.	Accounts with duplicate and or missing charges have been rebilled as of December 10, 2024.	December 10, 2024
We recommend Corporate Finance develop a work queue and review the Emergency Department (ED) accounts from April 2024 for potential duplicate charges and correct the entries manually, when necessary.	Revenue Integrity will run existing available audit report to identify ED accounts from April 2024 through November 2024 to identify any duplicate charges. Any duplicate charges identified will be corrected and accounts rebilled.	March 31, 2025
We recommend ED leadership reeducate the nurses on appropriate posting of IV charges in Epic.	ED leadership will reeducate ER staff regarding IV Hydration rules to include required EPIC Charge and documentation.	January 31, 2025
We recommend ED leadership do regular audits to monitor charges for accuracy.	ED leadership will conduct monthly IV Hydration audits. Random sample of ten (10) charts per month to be reviewed for documentation accuracy and appropriate charges.	January 31, 2025

<p>We recommend Corporate Finance continue to review all primary and secondary IV hydration, infusions and injection charges anytime new Epic features are implemented to ensure charges are accurate.</p>	<p>After future EPIC upgrades Corporate Finance will monitor for any impact on primary and secondary IV hydration, infusions and injection charges. In addition, Corporate Finance is currently testing EPIC AIC (Assisted Infusion Charging) a feature intended to improve the integrity of charge capture. Target is to roll out AIC into all areas across System by end of CY 2025.</p>	<p>December 31, 2025</p>
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cc: Shane Strum, Interim Chief Executive Officer, MHS



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

**Date:** December 12, 2024

**From:** Philoron A. Wright, II, Chief Executive Officer, MRHS  
 David Webb, Chief Financial Officer, MRHS

**Subject:** Action Plan: COMPLIANCE AUDIT OF THE DOCUMENTATION AND BILLING OF MAMMOGRAM PROCEDURES IN THE WOMEN'S IMAGING CENTER AT MEMORIAL REGIONAL HOSPITAL SOUTH

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
<p>We recommend that the Patient Financial Services (PFS) management reeducate the PFS team to ensure all written prescriptions contain the required elements including an accurate order date.</p>	<p>PFS management will continue to emphasize the importance of adhering to the 5 Rights Policy (<i>full name of pt, date, diagnosis/ symptom, exam/procedure, physician signature</i>) during regular team huddles, ensuring all team members understand the critical need for accuracy in prescription processing. The team has been informed that prescriptions with future dates will not be accepted, and in such cases, a new prescription must be obtained from the healthcare provider. Regular audits will be conducted to ensure compliance with these standards, and ongoing feedback will be gathered to reinforce adherence and identify areas for improvement.</p>	<p>This was discussed during the huddle on 11/27/24 and will continue to be emphasized in future huddles to ensure ongoing compliance.</p>

cc: Shane Strum, Interim Chief Executive Officer, MHS



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**To:** Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS  
**Date:** November 27, 2024  
**From:** Mario Salceda-Cruz, Chief Operating Officer, MPG <sup>DS</sup>  
 Esther Surujon, Chief Financial Officer, MPG <sup>ES</sup>  
**Subject:** **Action Plan: COMPLIANCE AUDIT OF EVALUATION AND MANAGEMENT SERVICES FOR MEMORIAL PRIMARY CARE PROFESSIONAL CODING AND BILLING**

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.	Claim issues identified were corrected during audit.	<b>Complete</b>
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.	<ol style="list-style-type: none"> <li>Education related to deficiencies in report will be provided by Coding and Compliance Auditors/Certified Coders.</li> <li>In addition, process will be created ensure MPC providers receive yearly provider education training and are included in MPE's current provider onboarding and ongoing education</li> </ol>	<p><b>Item 1</b> Will be complete by Jan. 30, 2025</p> <p><b>Item 2</b> will be initiated by 2/1/2025</p>

cc: Shane Strum, Interim Chief Executive Officer, MHS



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

**Date:** December 2, 2024

**From:** Patrick Brillantes, Senior Vice President-Service Lines, MHS  
 Meredith B. Feinberg, Vice President-Oncology Service  
 Esther Surujon, Chief Financial Officer, MPG

Signed by: Patrick Brillantes  
 EAEF57B231A643C... 12/13/2024

DocuSigned by: Meredith Feinberg  
 3CF081A8B7214FA... 12/12/2024

DocuSigned by: Esther Surujon  
 5B3194FFE1074E8... 12/12/2024

**Subject:** **Action Plan: Compliance Audit for MCI Hematology and Oncology Evaluation and Management services for Memorial Physician Group Professional Coding and Billing.**

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.	These accounts have been addressed during the audit and no further action is required.	Completed
We recommend that the Medical Director and the Administrative Director of the Oncology coordinate with the Director of Billing and Compliance to conduct a reeducation session for the providers on documentation guidelines, requirements for telehealth.	Provider re-education will be performed.	March 3, 2025
We recommend that the Medical Director and the Administrative Director of the Oncology to have the providers re-review the MPG Copy and Paste Policy.	MPG copy and paste policy will be re-reviewed by all providers	February 3, 2025

cc: Shane Strum, Interim President and CEO, MHS



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**To:** Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS  
**Date:** October 21, 2024  
**From:** Stephen Demers, Chief Executive Officer, MHM  
Veronica Bautista, Chief Financial Officer, MHM  
**Subject:** **Action Plan: FOLLOW- UP 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.

<b>Recommendations</b>	<b>Response/Action Plan</b>	<b>Estimated Completion Date</b>
We recommend the Case Management Department continue with the current process of daily reviews, and daily audits of selected Medicare and Medicare advantage accounts to ensure continuity of compliance with the MOON guidelines and requirements.	Case Management Department will continue ensuring that all appropriate patients receive MOON. They will continue daily concurrent review of patients as well as retrospective audits to ensure ongoing compliance. They will continue collaborating with PFS team to identify any new areas of opportunity that arise. PFS team will maintain the process to educate new and existing team members and will continue providing MOON to all appropriate patients prior to their transfer to patient floors.	Already in place and ongoing

cc: Shane Strum, Interim Chief Executive Officer, MHS