Memorial Healthcare System

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

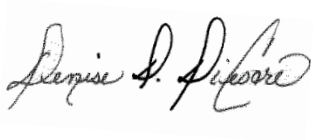
DATE: April 30, 2024

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

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

Attached is a copy of the fourth quarterly report of fiscal year 2024 summarizing the activities of the Internal Audit and Compliance Department from February 1, 2024, through April 30, 2024, 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
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:

- Federal and State Government Agency Audits, Interviews and Searches
- Records Management,
- Hazardous and Medical Waste Disposal, and
- Managed Care

Revised:

- None.

II. COMPLIANCE LEADERSHIP AND OVERSIGHT

The Compliance Officer attended the following meetings during the quarter:

- Florida Compliance and Privacy Consortium – 2 Sessions; and
- Becker's Hospital Review 14th Annual Meeting.

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, and
- ADA Walkthrough and Training: One Session.

IV. OPEN LINES OF COMMUNICATION

A. Hotline Calls

During the quarter, 46 calls, with no callbacks, were placed to the System's Compliance Hotline covering 36 new topics and two old topics. Three topics were compliance allegations (five calls). Two topics were HIPAA privacy allegation (two calls). All of the calls were investigated and one of the compliance allegations was substantiated.

Finally, four topics were uncompleted calls (four calls), and 27 new topics and two old topics (35 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. There was one referring physician who was sanctioned during the quarter.

B. Conflicts of Interest

The Calendar Year (CY) 2024 Conflicts of Interest Questionnaire cumulative employee completion rate is 12,622, of which 151 reported a possible or potential conflict of interest.

The Conflicts of Interest Subcommittee has been established to evaluate and manage disclosed potential conflicts. Policies and procedures, a risk evaluation tool, and training have been developed to assist the Subcommittee determine appropriate management of conflicts. Five of

eight employees have accepted a position on the Subcommittee.

VI. RISK ASSESSMENT, MONITORING & AUDITING

VII. RESPONSE & PREVENTION

A. Internal Audit

Recurring Quarterly Reports

South Broward Hospital District Construction Projects

Thirty payment vouchers for 13 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

Eleven 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.

Internal Audit of the Dual Access to Epic Assigned to Users at Memorial Healthcare System

Background

During the pandemic, personnel shortages were critical in the healthcare industry where it was essential to maintain staff levels to adequately treat and care for patients in a safe environment. Some Memorial Healthcare System (MHS) employees took second jobs to help in physician practices. In the past, this arrangement was prohibited because there was not an established way to monitor for employee activity that presented a potential conflict of interest, such as rounding on patients on behalf of the physician while working on MHS time. This scenario poses billing, liability, and timekeeping concerns as well. To make accommodations, controls were established to manage conflicts of interest by requiring disclosure of potential conflicts on the annual MHS Conflicts of Interest (COI) Questionnaires, user training, signing a memorandum of understanding (MOU) attestation, and Privacy and IT Security monitoring the users' activity. The Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules state that covered entities must take reasonable steps to limit the use or disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose and ensure the confidentiality, integrity, and availability of all electronic personal health information (ePHI). The Florida Statute on Security of Confidential Personal Information states that each covered entity shall take reasonable measures to protect and secure data in electronic form from unauthorized access. The MHS Business Ethics and Conflicts of Interest Standard Practice states that a conflict can be considered to exist when an employee holds a position with a vendor, contracted entity, or competitor of MHS. MHS Human Resources (HR) Policy E-38, titled "Outside Employment", requires employees to notify the Compliance Office of outside employment for potential conflicts to be evaluated. MHS employees with Epic access as part of their MHS job can obtain additional or secondary access to Epic for an outside employment. Dual access includes two network and two Epic accounts, community access is a separate account to MHS EPIC through Community Connect platforms such as Epic Community Connect, PlanLink or EpicCare Link. Multiple security templates are used for a second job with a vendor that is assigned to work at MHS, such

as TeamHealth and Envision. All accesses create separate event logs so that access can be monitored.

Observations

The System Access Team (SAT) identified eight MHS users with Epic dual access, two of which did not update their COI Questionnaire or sign the MOU. Three of the eight dual access users used their secondary access, and the SAT confirmed the dual access was no longer needed for the remaining five before removing it. One user accessed their non-MHS account while working on MHS time and the Privacy Department provided the user with training. We noted that five of the eight dual access users are not required to clock in and out and schedules are not always kept in the timekeeping software, therefore monitoring could not be completed. The SAT identified 198 MHS accounts that access Epic from the community platform that belong to users who might already have MHS Epic access. There is not a positive identifier to determine if two account holders have the same name or one user has two accounts. SAT also identified 1,547 Epic users with multiple security templates assigned to them. We evaluated 30 accounts and there were 23 with an appropriate ticket requesting access but the ticket did not include a MHS business reason to clarify whether the multiple security templates were different roles at MHS or for an outside employment.

Recommendations

We recommended developing a procedure where employees are required to update their COI Questionnaire disclosing a second job and signing the MOU prior to finalizing dual access. We recommended the dual access users be required to inform the SAT when dual access is no longer required, and that SAT periodically verify that the dual access is still being used. We recommended monitoring to verify that MHS employees are using dual access appropriately, including salaried employees. We recommended a process be developed to verify that users requesting access to MHS Epic do not already have an account and if they do, we recommended verifying there is valid reason for expanded access, users are appropriately provided supplemental access, and determining whether the access is for the job duties within MHS, for an outside activity, and length of time additional access is required.

Jeffrey Sturman, Senior Vice President and Chief Digital Officer and Frank Rainer, Senior Vice President and General Counsel, SBHD agreed with our findings and recommendations of this audit and have provided a detailed action plan.

Internal Audit of Purchases During Workday Cutover at Memorial Healthcare System

Background

Memorial Healthcare System (MHS) transitioned its Enterprise Resource Planning (ERP) system from Lawson (Infor) to Workday. The Go-Live for Supply Chain Management (SCM) was scheduled for January 1, 2024. Multiple milestones were set as part of the transition phase, one of which was the Ramped up Buying phase during Workday cutover period. Purchase Orders (POs) were issued from November 27, 2023, to December 18, 2023, to cover the blackout period of December 19, 2023, to December 31, 2023, when no POs would be issued using the Lawson requisition process. Leaders were advised to review requisitions during the Ramped up Buying phase dates for the forthcoming blackout dates to mitigate cutover impact. The purpose of this audit was to determine if adequate controls were in place during the Ramped up Buying phase of the Workday transition.

We obtained a download of 42,302 POs from the system SuperGL issued between the period of November 27, 2023, and December 18, 2023. Using RAT-STATS Random Number Generator, we selected 30 POs to check if appropriate controls were in place. MHS utilized the Requisition module of Lawson to manage the purchase requisitions and approvals.

Observations

We noted routine requisitions for the Operating Room (OR) par-orders, which is the level at which stock items are reordered and substituted items. POs are issued based on the requesting location and represent pre-approved contractual items. These POs are issued without going through an approval workflow. This workflow change was approved by the MHS facility Chief Operating Officers (CFOs) on May 20, 2022, to sustain efficiency in procuring items for OR. We were able to review the meeting agenda for this change. This change also aligns with the Central Supply workflow, which is on a perpetual inventory since the Lawson Go-Live in 1998. The perpetual inventory supply requisition items too do not go through an approval workflow before a PO is issued. Some items for Radiology are part of the perpetual inventory that do not go through an approval workflow. The remaining requisition from Laboratory, Home Infusion, other Radiology items, and Facilities, we noted controls were consistently applied for approvals.

There were no new non-approval changes applied to POs being issued during the Ramped up Buying phase.

Recommendations

None.

Saul Kredi, Vice President, SCM agreed with the result of this audit and since there were no recommendations, an action plan was not required.

B. Compliance

Compliance Audit of the 340B Program at Memorial Healthcare System Contract Pharmacies - FY 2024 Fourth Quarter

Background

The 340B Program is administered and overseen by the Health Resources and Services Administration (HRSA) which is within the Department of Health and Human Services (HHS). 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 include 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. To prevent duplicate discounts, Memorial Healthcare System (MHS) bills Medicaid for 340B purchased medications, meaning it carves-in Medicaid which is approved by HRSA/ Office of Pharmacy Affairs (OPA). Covered entities are subject to audit by the manufacturers and/or the federal government. 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 must have an established relationship with the covered entity such that the entity maintains records of the individual's care; and 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 such that responsibility for the care remains with the covered entity. Under the guidelines, an individual is not considered a patient of the covered entity if the only health care service received by the individual from the entity is the dispensing of a drug for subsequent self-administration or administration in the home setting. An individual may receive a 340B drug in

connection with treatment rendered outside the covered entity if the treatment is proximate in type and time to prior services provided by the covered entity. A non-hospital prescription is proximate in type and time to hospital-based services if the prescription or refill is presented within an appropriate time frame of the MHS encounter and the prescriber's services are part of the same continuum of care as the prior hospital encounter. A continuum of care exists if MHS makes a referral to the outside provider for follow-up care and there is an established patient care relationship with MHS. The only exception is patients of state-operated or -funded acquired immunodeficiency syndrome (AIDS) drug purchasing assistance programs. The Ryan White Clinic provides Human Immunodeficiency Virus (HIV)/AIDS treatment and related services to low-income people living with HIV/AIDS. All prescriptions written in this location and prescriptions of continuum care for Ryan White patients are 340B eligible. 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).

HRSA has developed guidelines to allow covered entities to contract with one or more outside pharmacies to act as dispensing agents. 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. MHS uses Verity Solutions Group, Inc.'s (Verity) application to help manage its contract pharmacy arrangements. There are seven contract pharmacies and a Ryan White Clinic. The purpose of this audit was to determine if MHS contract pharmacies are in compliance with the HRSA 340B Program requirements.

Observations

We examined 240 340B eligible contract pharmacy claims, 30 for each of the seven outpatient pharmacies and Ryan White clinic, of which 20 were specific targeted areas. All 240 340B contract pharmacy claims met the 340B eligibility requirements.

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 Malnutrition at Memorial Regional Hospital

Background

Malnutrition refers to deficiencies, excesses or imbalances in intake of energy and/or nutrients. Malnutrition may be undernutrition and overnutrition that is associated with disease that consists of a combination of reduced food intake and varying degrees of acute or chronic inflammation, leading to altered body composition and diminished biological function. Secondary diagnoses are those impacting clinical evaluation, therapeutic treatment, diagnostic procedures, extend the length of stay or nursing care required. The Academy of Nutrition and Dietetics (The Academy) and American Society for Parenteral and Enteral Nutrition (ASPEN) have developed criteria which assists the process of standardizing definitions of malnutrition. Memorial Regional Hospital (MRH) Registered Dieticians (RD) use these criteria when assessing patients at risk of malnutrition. When malnutrition is determined, diagnosis and nutrition intervention is

recommended by the RD. The attending provider can agree or disagree with the suggested diagnosis and intervention. Also, providers are able to diagnose malnutrition and order intervention without the consultation of an RD.

Medicare reimburses inpatient hospital services under the Inpatient Prospective Payment System (IPPS), based on appropriate weighting factors assigned to each Medicare Severity Diagnosis Related Group (MS-DRG). When a patient is admitted as an inpatient for a primary reason other than malnutrition but meets criteria for malnutrition, it is classified as a major complication or comorbidity (MCC). Adding MCC to a Medicare claim can result in a higher Medicare payment. The purpose of this audit was to determine if documentation supports the criteria for malnutrition and determine the accuracy of coding, charging and billing for inpatient accounts at MRH.

Observations

Of 30 patient accounts reviewed, 27 had consultation for nutrition assessment. These patients had initial nutrition assessment and follow up reassessments according to MRH policy. Attending providers reviewed and agreed with the suggested diagnosis and interventions. Three patient accounts did not have nutritional assessment documented by RD. Two of the three patient accounts indicated malnutrition assessment and diagnosis were documented by the attending provider as both patients had malnutrition caused by unchanged chronic diseases in the recent admissions. Documentation for one of the three patient accounts indicated the admitting provider agreed with the malnutrition diagnosis from a recent admission but nutritional assessment or intervention was not documented. Discharge notes documented by a different provider indicated malnutrition was ruled out.

Twenty-nine of 30 accounts were coded with the MCC diagnosis of malnutrition and severity accurately. One account coded with malnutrition did not concur with documentation. The account was reviewed by a clinical documentation integrity specialist (CDIS), Health Information Management (HIM), Memorial Healthcare System (MHS) while the patient was in the hospital for accuracy of diagnosis. A query for clarification was sent to the specific provider as documentation did not support the malnutrition diagnosis and severity. The provider updated the discharge summary documentation to include malnutrition is ruled out however, coding was completed prior to the query being placed and documentation updated. According to HIM management, this account is an outlier where communication was not followed according to process for CDIS to notify the coder by email when there is response to a query from the provider after coding initially completed with an update to the documentation. Subsequently, HIM corrected the account, reeducated specific CDIS to always follow the current process and Accounts Receivable Management (ARM) rebilled. There was no change to MS-DRG. All 30 accounts were paid according to the assigned MS-DRG.

Recommendations

None.

Peter Powers, Chief Executive Officer, MRH and Walter Bussell, Chief Financial Officer, MRH agreed with the result of this audit and since there were no recommendations, an action plan was not required.

Compliance Audit of the Emergency Medical Treatment and Labor Act at Memorial Regional Hospital

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 the EMTALA law. 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 when medically necessary and when certain conditions are met to the next closest health care facility with the capacity to provide stabilizing treatment. The Centers for Medicare and Medicaid Services (CMS) outlined the responsibilities to comply with the EMTALA statute. Violations of EMTALA results in large fines, and possible termination of the Medicare provider agreement for the facility involved.

Memorial Regional Hospital (MRH) has a dedicated Emergency Department (ED) catering to adult individuals seeking emergency services. The purpose of this audit is to determine if MRH main ED is in compliance with EMTALA regulations regarding policies and procedures, signage, triage, registration, MSE, stabilizing treatment, transfers in and out, and documentation.

Observations

We observed that the requirements for EMTALA were met on adopting policies/procedures adhering to EMTALA, and using appropriate signage, transfer logs and physicians' on-call lists. All 35 accounts reviewed have complete documentation of triage including timely MSE and stabilizing treatment provided. Out of 35 accounts, six were transferred out of MRH ED in stable condition. Of the six, one was a transfer back to MRH Behavioral Health unit as the patient was cleared for admission and did not need a transfer form. One was a transfer to a non-Memorial Healthcare System (MHS) facility as per patient's physician request and the remaining four were transferred for admission to another MHS facility as inpatient admission at MRH was at capacity. We noted an opportunity for improvement on the completion of the transfer form. For the non-MHS facility transfer, the form was missing the date and time for the part where the physician certifies that the patient is stable for transfer or any other acceptable condition, and the name of the accepting staff from the receiving facility. On three accounts that were transferred out to another MHS facility, the forms were noted that patient provided verbal consents. These were not EMTALA violations as documentation was noted in the medical records that were transferred with the patient and written consent is only necessary for transfer requests by patient or family. For the transfers in from another MHS facility, we noted one out of nine transfers was missing the scanned form in Epic. As this is a MHS transfer, all necessary medical information were noted in Epic and hence, not an EMTALA violation. We noted on all but one account that the time stamps for registration were completed after the physician had seen the patient and stabilizing treatment were provided. According to Patient Financial Service (PFS) management, documentation showed attempt to register the patient after being seen by the physician and provision of stabilizing treatment. We noted registration was completed and verified after the patient was transferred to another MHS facility.

Recommendations

We recommended ED leadership to reeducate the staff on the completeness of the transfer form which includes scanning the form in Epic for the transfers in and conduct regular reviews to monitor for completeness. We recommended Transfer Center management reeducate the

nurses on the procedure for filling the transfer form particularly when patient is unable to sign the form and perform regular audits to monitor for completeness.

Peter Powers, 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 Memorial Outpatient Physical Therapy at Home Program

Background

The Centers for Medicare and Medicaid Services (CMS) covers outpatient (OP) physical therapy (PT) services when services are medically necessary, the Plan of Care (POC) is established and reviewed periodically, and the individual is under the care of a physician. The POC must be certified by a physician/non-physician practitioner (NPP) for coverage and payment. Timely certification of the initial plan is met when done in the 30 days following the first day of treatment. Recertifications should be signed whenever there is a significant modification of the plan or at least every 90 days after initiation of treatment. To bill Medicare, total timed codes in minutes and total treatment time must be documented in the medical record for each service date. The total timed codes in minutes refer to the total minutes for the timed Current Procedural Terminology (CPT) codes which represents each 15 minutes increment the therapists performs one-on-one treatment such as therapeutic exercise and therapeutic activity. The total treatment time refers to the total timed codes plus the untimed codes, which are one-time therapy services such as the evaluation time. Memorial Rehabilitation Institute at Memorial Regional Hospital South (MRHS) partnered with Luna to expand access for patients to have OP PT services in-home. As per the agreement, Luna will deliver PT by a duly licensed, qualified therapist. Luna will be responsible for the scheduling, coding, charging, and billing under Memorial Healthcare System (MHS) name, federal Employer identification (ID) number, National Provider Identifier (NPI) and applicable provider number, and for the collection of all services provided. In return, MHS will compensate Luna for the services per visit. MHS Compliance and Internal Audit Department's audit of this program was at the request from management to evaluate the design, controls and performance of the Memorial OP PT at Home Program.

Observations

Luna medical documentation and claims are maintained in Luna's electronic health records (EHR). Audit access was requested to Luna's EHR but denied. We requested and reviewed copies of clinical documentation and claims for 37 accounts. All met medical necessity, had a referral for the PT services and were under the care of a physician. We noted that all accounts have initial evaluations, completed POCs, progress notes every 10th treatment day, and the therapists' dated and timed signature on all notes. For the 16 Medicare accounts, 12 had the initial certification complete with the physician's dated and timed signature, one had the physician's signature but did not approve the POC, and three accounts were missing the initial certification. Four out of eight accounts with recertifications, were appropriate since modifications were made to the patient's POC. For all 16 Medicare accounts, we noted in the documentation the minutes spent for each timed therapy procedures but were unable to locate documentation of the total timed codes in minutes and the total treatment time. Medicare Advantage (MA) accounts should follow CMS coverage guidelines as per CMS Final rule effective January 1, 2024. For the 12 MA accounts, nine had the initial certifications and three accounts did not. Three out of five accounts with recertifications were appropriate since modifications were made to the patient's POC. For all 12 MA accounts, we were unable to locate documentation for the total timed codes in minutes and the total treatment time.

The remaining nine accounts were classified as Medicaid Managed, Commercial payors and self-pay patients and may follow different documentation guidelines. Subsequently, Luna started a remediation plan which addresses the findings discussed for the documentation errors.

The insufficient documentation for the total timed codes in minutes and the total treatment time made the claims unbillable for the 16 Medicare and the 12 MA accounts. We identified other opportunities in claims processing. There were 183 dates of service (DOS) for the 16 Medicare accounts. We noted four DOS claims had codes for therapy procedures not supported by documentation, 17 DOS claims had charging errors caused when the total timed codes were incorrectly converted to units, and 28 DOS claims billed the incorrect units charged or reported incorrect charge master amounts. There were 195 DOS for the 12 MA accounts. We noted three DOS claims had codes for therapy procedures not supported by documentation, 40 DOS claims had the incorrect units charged, and 58 DOS claims billed the incorrect units charged or reported incorrect charge master amounts. We noted that for one Medicare account, the incorrect claim form was used for the month of service. We noted that for one MA account, the incorrect claim form was used for three months of service. The billing errors from the insufficient documentation resulted in a Medicare overpayment of $54,186.43 and loss from expected revenue of $210,338.43 for the unbillable claims as based on the average reimbursements from the 2023 Medicare and MA claims and refund for overpayment. For the two Medicaid accounts, we noted documentation supported codes used on all 28 DOS claims. We noted 21 DOS claims had the incorrect units charged, 22 DOS claims had billed the incorrect units charged or reported incorrect charge master amounts. On the Commercial payors, we noted two DOS claims with codes for therapy procedures not supported by documentation, 23 DOS claims had the incorrect units charged and 23 DOS claims had billing errors. Invoices were noted for the remaining three self-pay patients as appropriate. We noted Modifier 59 was used on some DOS claims in 2024 for all payors. As per CMS, Modifier 59 identifies distinct, non-evaluation/management procedures or services that are not normally reported together but were performed on the same day. We verified that Modifier 59 was not appropriate as the services are not distinct or meet pairing restrictions as per National Correct Coding Initiative (NCCI) edits. We also observed that for DOS in 2024, Medicare and MA claims were not submitted and did not follow MHS monthly cadence for billing. Subsequently, as part of Luna's remediation plan, processes were developed to address the coding and billing errors identified in the audit.

The 37 patient accounts had 496 DOS claims reviewed, of which 369 DOS claims were submitted to payors and 252 DOS claims were paid. Of the 252 DOS claims paid, 121 were Medicare accounts, 67 were MA accounts, 18 were commercial payors, and 46 were self-pay accounts. Medicare denied 26 DOS claims with one of the reasons cited as secondary to maximum benefit has been reached for the time period or occurrence. All financial reports are recorded under Luna's EHR, and we requested them for review. We noted that some accounts were categorized under the inappropriate payor classification, which can affect the accuracy of the financial reports. Luna had billed Memorial in error $8,055 less for the invoice on the completed visits for the month of June 2023. We verified 54 duly licensed and credentialed physical therapists who were not sanctioned from participation from any federal health care program. Two of the therapists were current MHS employees and had disclosed employment with Luna on their conflicts of interest (COI) questionnaire as per MHS policy.

Recommendations

We recommended monitoring the process developed to ensure certification and recertifications have the necessary physician signature approving the POC. We recommended monitoring PT treatment notes to ensure completion of the template on the total timed codes in minutes and total treatment time for future encounters. We recommended Luna report the total pending certifications with the monthly financial reports. We recommended reeducating the therapists on the Medicare documentation requirements for obtaining recertifications when changes are made on the POC. We recommended refunding the claims on all Medicare accounts noted with insufficient documentation from April 2023 and on all MA accounts from January 2024, when necessary. We recommended to hold the claims with insufficient documentation errors for all Medicare, and MA accounts. We recommended monitoring the developed process when the charge master rates are updated and verify the charge rates on the claims before submission to the payors. We recommended to review the existing process for charging units of service and fix logic to limit errors with claims not matching treatment documentation. We recommended to correct the coding and billing errors noted, and utilization of the UB-04 for Commercial and Medicaid managed claims. We recommended developing a process to review the claims for Medicare and MA accounts before submission to the payors. We recommended MHS and Luna perform routine audits to ensure claims follow CMS guidelines. We recommended developing a process to report payments and denials routinely and allow for MHS and Luna to monitor and reconcile payments for the services provided. We recommended developing a process to allow for denials to be reviewed in a timely manner so claims can be appealed and resubmitted to payors. We recommended developing a process to provide documentation of Luna's therapy services including claims in MHS Epic system. We recommended reviewing the monthly financial reports to validate data and reclassifying payor classification. We recommended MHS to work out a plan with Luna regarding the loss of expected revenue and invoices paid to Luna which includes the miscalculation for the month of June.

Phil A. Wright, II, Chief Executive Officer (CEO), MRHS and David Webb, Chief Financial Officer (CFO), MRHS agreed with the findings and recommendations of this audit and have provided an action plan.

Compliance Audit of Breast Oncology Procedures for Memorial Physician Group Professional Coding and Billing

Background

Memorial Cancer Institute (MCI) offers nationally recognized breast cancer care with a team of highly skilled medical and surgical oncologists who deliver leading treatments. Centers for Medicare and Medicaid Services (CMS) requires reasonable documentation of medical and surgical services provided by the healthcare providers in all settings. The documentation validates medical necessity, place of service, and correct reporting of the services billed to the insurances for reimbursement. The physicians and the Advanced Practice Registered Nurses (APRNs) report health care services using code sets to identify medical procedures and professional services on the health care billing claims. The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10–CM) diagnosis codes are used to indicate the reason for care. The Current Procedural Terminology (CPT) codes are used to report services and procedures. Modifiers are appended to the CPT codes to report services that are altered under certain circumstances. CMS has established a global surgical package to ensure that Medicare Administrative Contractors (MACs) make payments for the same services consistently across all jurisdictions nationwide. CMS's Center for Program Integrity manages the Open Payments

Program, a federally mandated program to increase the transparency of financial relationships between the drug and medical device companies and the healthcare providers.

Observations

We reviewed 95 accounts for eight physicians and eight APRNs. Some findings may overlap. We noted that 77 of the 95 accounts reviewed used CPT procedure codes for billing that were supported by the medical record documentation. There were thirteen accounts in which documentation supported billing for different or additional CPT codes than billed. There were five accounts that documentation did not support billing for the services. Three were for laboratory (lab) tests that were billed without appropriate orders and only two tests were completed. Charges are automatically dropped when labs results are available. Subsequent to this finding, we were told that the lab orders were verbal and phone orders not documented in Epic. EPIC Information Technology (IT) team corrected the technical documentation gap ensuring prospectively that verbal and phone orders are routed to the provider for signature in EPIC. One was for durable medical equipment (DME) that was ordered without the required quantity and billed before the surgical procedure and without documented proof of equipment delivery. Finally, one account for biopsy lacked appropriate documentation. There were 21 of 30 accounts that needed a billing modifier that were appropriately applied. Reimbursement was not affected because the modifiers were informational in nature. We noted that 59 accounts used the ICD-10-CM codes in accordance with the coding guidelines and opportunities for improvement were identified in assigning accurate ICD-10-CM diagnosis codes to the highest specificity in the remaining accounts. There were 42 accounts in which payment was denied for authorization related issues, additional documentation requests, inclusive services that are not separately billable, or claims that needed to be filed under the correct payor. All accounts identified for denials are expected to be paid except for two accounts that were denied for authorization related issues. The CMS Open Payments were reviewed for all providers and payment category errors were identified for two physicians.

Recommendations

We recommended that Memorial Physician Group (MPG) Business Office correct and rebill or refund accounts as appropriate. We recommended that the MPG Business Office reeducate providers on medical record documentation, coding, and billing of breast oncology procedures, and ensuring there are signed orders for lab services. We recommended Lab Services and Oncology Services continue to research the cause and monitor the process for lab tests being drawn, resulted and billed based on verbal orders without documentation. We recommended Lab Services reeducate the lab technicians to appropriately route verbal and phone lab orders in Epic to ordering providers for signature prior to drawing and resulting labs. We recommended MPG Business Office retrospectively review Breast Oncology Lab Services for orders signed by a laboratory technician and refund as appropriate. We recommended MPG Business Office develop, implement, and monitor the process to ensure there is a physician order for DME that contains the quantity to be dispensed if applicable and is delivered to the patient prior to billing. We recommended MPG Business Office initiate a retrospective review of DME services to identify charge capture errors and correct and rebill if appropriate. We recommended that MPG physicians ensure that incorrect Open Payments data is disputed and corrected.

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.

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.

SBHD Construction Projects
Period Ending 4/30/2024

Exhibit A

	Interventional Radiology Turner Construction Co. #401622 MHS	Urgent Care Center Miami Gardens Gerrits Construction Inc. #650322 MHS	Central Sterile Processing Thornton Construction Co. Inc. #430122 MHW	Wind Retrofit Turner Construction Co. #409020 MRH	Family Birthplace Turner Constuction Co., Inc. #400622 MRH
	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	$ 1,826,577	$ 1,929,942	$ 1,620,971	$ 4,924,483	$ 43,850,159
Prior Change Orders					
Budget Transfer					
Current Change Orders	(394,612)		(261,732)		
Prior Owner Purchase Orders		(180,621)		(270,947)	(9,703,000)
Current Owner Purchase Orders		890		(104,688)	
Current Contract Sum to Date	$ 1,431,965	$ 1,750,211	$ 1,359,239	$ 4,548,849	$ 34,147,159
Previous Payments		1,725,175		4,548,849	13,382,548
1	32,243	13 24,145	1 103,753	23 0	12 1,340,331
2	114,029		2 185,026		13 1,549,153
3	16,617		3 580,220		14 1,805,685
4	46,681				
Total Payments	209,570	1,749,320	868,999	4,548,849	18,077,715
Balance	$ 1,222,395	$ 891	$ 490,240	$ 0	$ 16,069,444
Owner Purchased Materials					
Retainage	3,574		35,538		964,435
Payments	209,570	1,749,320	868,999	4,548,849	18,077,715
Work completed	$ 213,144	$ 1,749,320	$ 904,537	$ 4,548,849	$ 19,042,150
Status	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 4/30/2024

Exhibit A

	Main Electrical Panel Upgrade Thornton Construction Co. Inc. #410222 MRHS	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
	Amount	Amount	Amount	Amount	Amount
Original Contract Sum	$ 1,120,307	$ 10,650,417	$ 35,067,236	$ 86,165,924	$ 13,613,113
Prior Change Orders			(5,101,409)	(15,571,906)	
Budget Transfer					
Current Change Orders					
Prior Owner Purchase Orders	(75,607)	(2,591,108)	(750,000)	162,630	(2,804,433)
Current Owner Purchase Orders		108,194			99,239
Current Contract Sum to Date	$ 1,044,700	$ 8,167,503	$ 29,215,826	$ 70,756,649	$ 10,907,919
Previous Payments	288,708	6,947,788	27,791,202	61,673,884	9,458,904
	3 234,803	10 531,480		28 688,129	18 315,195
	4 428,423			29 269,475	
	5 23,369			30 175,524	
Total Payments	975,303	7,479,269	27,791,202	62,807,012	9,774,099
Balance	$ 69,397	$ 688,234	$ 1,424,624	$ 7,949,637	$ 1,133,820
Owner Purchased Materials					
Retainage	21,758			1,713,539	514,426
Payments	975,303	7,479,269	27,791,202	62,807,012	9,774,099
Work completed	$ 997,061	$ 7,479,269	$ 27,791,202	$ 64,520,551	$ 10,288,525
Status	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 4/30/2024

Exhibit A

	MOB II 3rd Floor Time Share Fit Out Thornton Construction Co. #830922 MHM	JDCH ER Room Finishes Engel Construction, Inc. #460120 JDCH	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	Amount	Amount
Original Contract Sum	$ 2,148,948	$ 1,920,630	$ 3,318,035	$ 16,401,716	$ 108,993,259
Prior Change Orders			(578,606)		
Budget Transfer					
Current Change Orders					
Prior Owner Purchase Orders	(450,000)	(218,164)	182,424	(3,300,002)	(15,093,946)
Current Owner Purchase Orders		39,487			(19,979)
Current Contract Sum to Date	$ 1,698,948	$ 1,741,953	$ 2,921,853	$ 13,101,714	$ 93,879,334
Previous Payments		316,444	2,808,328	4,929,828	87,400,462
1	326,923	7 68,623		12 447,311	28 372,456
2	327,814	8 100,126		13 389,814	
3	158,577	9 257,701		14 487,443	
Total Payments	813,314	742,894	2,808,328	6,254,396	87,772,918
Balance	$ 885,634	$ 999,059	$ 113,525	$ 6,847,318	$ 6,106,416
Owner Purchased Materials					
Retainage	35,243	39,100		216,138	
Payments	813,314	742,894	2,808,328	6,254,396	87,772,918
Work completed	$ 848,558	$ 781,993	$ 2,808,328	$ 6,470,533	$ 87,772,918
Status	Active	Active	Active	Active	Active

Memorial Healthcare System
RFP and Competitive Quote Audits

	RFPs	Current Phase - 4th Quarter FY 2024	Audited Through	Exceptions
1	Joint Replacement RFP	Advertising/Mailing	Design	None
2	Janitorial Services RFP	Ranking & Selection	Design	None
3	Rewards and Recognition RFP	Ranking & Selection	Design	None
4	Contact Center Augmentation RFP	Ranking & Selection	Advertising & Mailing	None
5	Parking Management Service	Ranking & Selection	Design	None
6	Employee Survey Tool	Ranking & Selection	Analysis	None
7	Talent Acquisition Center Exterior Painting RFQ	Analysis	Analysis	None
8	Clinical Engineering Computerized Maintenance Management System	Selection	Oral Presentation	None
9	Audit Management Software RFQ	Selection	Selection	None
10	Compliance Program Evaluation RFP	Oral Presentation	Oral Presentation	None
11	Merchant Services Processor RFP	Selection	Analysis	None

Memorial Healthcare System
RFP and Competitive Quote Audits

	Completed Competitive Quotes	Amount $	Exceptions
1	Laboratory Equipment for MRHS	428,759	None
2	Construction of Kosher Lounge at JDCH	405,863	None
3	Patient Data Privacy Data Source & Management Services for MHS	374,120	None
4	Network Upgrade at MRHS	364,485	None
5	Three Year Service Maintenance of Cardiac Equipment for Operating Room at MRH	357,194	None
6	Landscaping Agreement for MHM	326,294	None
7	Healthcare Advisory Services for MHS	305,000	None
8	Sterilization Equipment for Operating Room at MHM	294,741	None
9	Influenza Vaccines for MRH	246,663	None
10	Equipment Rental for the Operating Room at MRH	241,780	None
11	Landscaping Agreement for MRH	221,522	None
12	Rental Equipment for Laboratory at JDCH	210,151	None
13	Patient Beds for MRHS	196,986	None
14	Caterpillar Generator Warranty for MRH	183,900	None
15	Radiology Equipment for MPG	179,343	None
16	Service Maintenance for Surgical Robotic Equipment for MHP	172,000	None
17	Laboratory Equipment for MRH	148,186	None
18	Consumer Engagement Solution for MHS	144,000	None
19	Service Agreement Renewal for Fire Alarm and Electrical Maintenance at MHM	134,012	None
20	Replacement of Cameras for Medical Office Building at MHW	129,692	None
21	Cardiovascular Equipment for MRH	123,547	None
22	Fiber Optic Upgrade at MRH	117,619	None
23	Labor and Deliivery Patient Bed Replacement at MHM	502,299	None
24	Tetanus Medication for Speciality Pharmacy at MHW	462,000	None
25	Two Year Microsoft Volume Licenses for MHS	4,688,100	None
26	Five Year Insulin Management Software and Service for MHS	2,265,000	None
27	Pharmacy Technology Solution for MHS	2,037,500	None
28	Workday Managed Services for MHS	1,255,982	None
29	Zebra Mobile Computers for MHS	108,362	None
30	Operating Room Equipment for MHM	101,138	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	None.		
January 31, 2024	None.		
April 30, 2024	None.		

Memorial Healthcare System
Non Audit Engagement Report
Q4 FY 2024

Quarter Ended	RSM US LLP Engagement:		
Q4 FY2024	For professional services rendered and expenses incurred in connection with implementing GASB 96 Technical subscription based information technology arrangements accounting.	$	64,513
	Total	$	64,513
Q3 FY2023	Total spend, provided for comparative purpose	$	9,765

Quarter Ended	Zomma Group LLP Engagement:		
Q4 FY2024	For professional services rendered and expenses incurred in connection with Non Audit Engagements.	$	-
Q3 FY2023	Total spend, provided for comparative purpose	$	-

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

Date: December 21, 2023

From: Jeffrey Sturman, Senior Vice President and Chief Digital Officer, MH
Frank Rainer, Senior Vice President & General Counsel, SBHD

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Subject: **Action Plan: INTERNAL AUDIT OF THE DUAL ACCESS TO EPIC ASSIGNED TO EMPLOYED USERS AT MEMORIAL HEALTHCARE SYSTEM**

Attached is our Action Plan for, 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 developing a procedure where employees are required to complete their Conflicts of Interest (COI) Questionnaire to disclose a second job or other potential conflict prior to finalizing dual access.	For new employees: System Access Team ("SAT") is working with Talent Acquisition Center ("TAC") to add a new question to their questionnaire to see if the employee will continue to work with another organization and MHS. Then follow up with Compliance for feedback/approval. For existing users: SAT to escalate to compliance to verify if approved and/or complete COI and Memorandum of Understanding ("MOU").	4/30/24
We recommend developing a policy on the management and maintenance of signed Memorandum of Understanding (MOU).	HR needs to decide how this is going to be communicated to employees. Should be part of "Employee Conduct"? Needs to be owned by HR.	Human Resource to design a process.

We recommend the dual access user be required to inform System Access Team (SAT) when dual access is no longer required.	The quarterly Periodic Access Review (“PAR”) shows the manager/sponsor the access the user has and should let SAT know if the access needs to end. OR Site verification completed by the site manager/sponsor, is done on a monthly basis. If they have multiple templates, that is identified on the quarterly PAR.	Currently Available
We recommend SAT periodically verify that the dual access is still being used.	For users with dual access identified, there will be regularly scheduled audits to confirm if dual access is still required.	4/30/24
We recommend monitoring be developed to identify when Memorial Healthcare System (MHS) employees with dual access are using the appropriate user access.	SAT is identifying the users with dual access with new Active Directory (“AD”) groups. With these new AD groups, options will be evaluated within Fairwarning (“FW”) to ascertain if monitoring can be done. FW findings will be shared once evaluation is completed. 90 days is required for the evaluation by Fairwarning. If Fairwarning is unable to monitor dual access/account, MHS leadership to determine if manual audit should be done. OR MHS to stop allowing users to do dual jobs.	4/30/24 7/30/2024 (FW)

We recommend developing a procedure to ensure that salaried employees with dual access can be monitored for appropriate user access for their MHS role or their non-MHS role.	SAT is identifying the users with dual access with new AD groups. With these new AD groups, options will be evaluated within Fairwarning ("FW") to ascertain if monitoring can be done. FW findings will be shared once evaluation is completed. 90 days is required for the evaluation by Fairwarning. If Fairwarning is unable to monitor, MHS leadership to determine if manual audit should be done. OR Stop allowing users to do dual jobs.	Identifying AD groups- 4/30/24 7/30/2024 (FW)
We recommend a process is developed to verify that users requesting access to any platform of MHS Epic does not already have an account.	Epic does not allow for duplicate users. If an Epic account is requested for a user with existing access, SAT will follow the process mentioned above for existing users.	4/30/24
We recommend that the new requests follow a process to ensure there is valid reason for dual access, a MOU is signed with HR, and the user updates the COI Questionnaire disclosing the potential conflict.	For new employees: SAT is working with TAC to add a new question to their questionnaire to see if the employee will continue to work with another organization and MHS. Then follow up with Compliance for feedback/approval. For existing users: SAT to escalate to compliance to verify if approved and/or complete COI and MOU.	4/30/24
We recommend monitoring that the users are appropriately provided supplemental access.	We currently require approval for supplemental access and guidance from the Epic team(s) on what level of access the user needs based on the request.	Currently happening

We recommend developing process to manage requests for expanded security access to MHS Epic to determine whether the access is for the job duties within MHS, for an outside activity, and length of time additional access is required.	We will be implementing to consistently entering an end date on the Epic template for additional access.	4/30/24
We recommend that if the additional security access is for outside activities, the request be approved by HR, a MOU is obtained, the COI Questionnaire is updated, and the Compliance and Internal Audit Department has evaluated the potential conflict of interest,	For new employees: SAT is working with TAC to add a new question to their questionnaire to see if the employee will continue to work with another organization and MHS. Then follow up with Compliance for feedback/approval . For existing users: SAT to escalate to compliance to verify if approved and/or complete COI and MOU.	4/30/24

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: June 19, 2024

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

Subject: **Action Plan: COMPLIANCE AUDIT OF THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT 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 Emergency Department (ED) leadership reeducate the staff on the completeness of the transfer form which includes scanning the form in Epic for the transfers-in to Memorial Regional Hospital (MRH) ED and conduct regular reviews to monitor for completeness.	The ED clinical managers will receive re-education on the importance of completing the transfer form accurately. The completed form will be scanned into EPIC for all transfers leaving the ED. In addition, ED Leadership will conduct quarterly audits of the transfer documentation.	July 1, 2024
We recommend Transfer Center management reeducate the nurses on the procedure for filling the transfer form particularly when patient is unable to sign the form and perform regular audits to monitor for completeness.	The Transfer Center nurses were reeducated during the course of the audit, on 5/10/24, regarding obtaining signatures from two RN's when the patient is unable to sign. The chart auditing is on going.	June 6, 2024

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: June 21, 2024

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

Subject: **Action Plan: COMPLIANCE AUDIT OF THE MEMORIAL OUTPATIENT PHYSICAL THERAPY AT HOME PROGRAM**

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 monitoring the process developed to ensure certification and recertifications have the necessary physician signature approving the plan of care (POC).	Luna will provide detailed reporting on POCs monthly going forward.	7/1/24
We recommend monitoring physical therapy (PT) treatment notes to ensure the completion of the template on the total timed codes in minutes and total treatment time for future encounters.	MHS has validated that the templated notes have been corrected and meets requirements. Operational leadership will conduct random audits to ensure this is consistently correct.	6/12/24
We recommend Luna report the total pending certifications with the monthly reports.	Luna will include in monthly reports, example shared on 6/21 pending approval by MHS	7/30/24
We recommend reeducating the therapists on the Medicare documentation requirements for obtaining recertifications when changes are made on the POC.	Operational leadership to ensure Luna updates their processes with staff to send recertifications if plan has changed.	7/30/24

We recommend refunding the claims on all Medicare accounts noted with insufficient documentation from April 2023 and on all Medicare Advantage (MA) accounts from January 2024, when necessary.	2023 Medicare claims and 2024 MA claims refund submitted 6/13 to payers. Patient refunds submitted 6/21. Secondary payer claims cancellation pending.	7/15/24
We recommend holding the claims with insufficient documentation errors for all Medicare, and MA accounts in 2024.	All claims were put on hold 5/9 and none have been released for any payer. 100% audit of all claims for 90 days will be conducted by MHS personnel before submission	5/9/24
We recommend monitoring the developed process when the charge master rates are updated and verify the charge rates on the claims before submission to the payors.	Luna will request charge master updates in April each year as MHS updates the charge master for the start of each fiscal year on 5/1	4/15/25
We recommend reviewing the existing process for charging units of service and fix logic to limit errors with claims not matching treatment documentation.	This has been corrected and will be monitored during auditing of claims.	6/15/24
We recommend correcting the coding and billing errors noted particularly on reporting the hospital taxonomy code, and utilization of the Uniform Billing-04 (UB-04) for Commercial and Medicaid managed claims.	This has been corrected, Revenue Cycle leadership has reviewed and approved the release of 20 claims that will go to commercial payers to ensure expected payment. Auditing will continue for remaining claims.	6/25/24
We recommend developing a process to review the claims for Medicare and MA accounts before submission to the payors.	MHS Revenue Cycle will be conducting a 100% audit of all claims prior to submission for 90 days. They will then step down to 75%, 50% and 25% for each subsequent 90 days period, subject to results of the audit. There will be 1 full year of audits prior to submission before switching	6/30/25

	to 5% audit post submission.	
We recommend Memorial Healthcare System (MHS) and Luna perform routine audits to ensure claims follow Centers for Medicare and Medicaid Services (CMS) guidelines.	Luna will be conducting their own internal 100% audit in addition MHS Revenue Cycle will be conducting a 100% audit of all claims prior to submission for 90 days. They will then step down to 75%, 50% and 25% for each subsequent 90 days period, subject to results of the audit. There will be 1 full year of audits prior to submission before switching to 5% audit post submission.	6/30/25
We recommend developing a process to report payments and denials routinely and allow for MHS and Luna to monitor and reconcile payments to the services provided.	MHS will establish a denial review process on a monthly cadence along with financial reporting review.	11/30/24
We recommend developing a process to allow for denials to be reviewed in a timely manner so claims can be reappealed and resubmitted to payors.	MHS will establish a denial review process on a monthly cadence along with financial reporting review.	11/30/24
We recommend developing a process to transfer documentation of Luna's therapy services including claims into the MHS Epic system.	Luna will provide MHS with a list of all patients and their therapy dates for inclusion in their Epic record. In the event of a medical records request, this will trigger MHS to reach out to Luna for the medical records to include. This process will be manual initially but Luna will work with MHS IT to develop some automation. MHS Revenue Cycle does not need claims data loaded into Epic.	11/30/24
We recommend reviewing the monthly financial reports	Luna Revenue Cycle system was updated to	6/15/24

to validate data submitted and reclassifying payor classification as required.	classify insurance plans correctly and payer classification will be validated during auditing.	
We recommend MHS work out a plan with Luna regarding the loss of expected revenue ($210,338.43) and invoices paid to Luna ($203,965 for Medicare and MA plans) which includes the miscalculation for the month of June.	MHS is working with Luna to reconcile this.	11/30/24

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: **May 20, 2024**

From: Mario Salceda-Cruz, Chief Operating Officer, MPG MS
Esther Surujon, Chief Financial Officer, MPG ES
Patrick Brillantes, Senior Vice President Service Lines, MHS PB

Subject: **Action Plan: COMPLIANCE AUDIT OF BREAST ONCOLOGY PROCEDURES 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 Memorial Physician Group (MPG) Business Office correct and rebill or refund accounts as appropriate.	Identified transactions are in review and will be processed for refund if applicable.	8/1/2024
We recommend that the MPG Business Office reeducate providers on medical record documentation, coding, and billing of breast oncology procedures, and ensuring there are signed orders for lab services.	Reeducation for documentation coding and procedures will be provided. The business office cannot review lab orders prior to billing as the reimbursement is minimal and it would be cost prohibitive. The laboratory personnel should ensure they have an order prior to resulting a lab test and charges should be dropping once lab is resulted.	8/31/2024 for training. Can not accommodate 4th item related to lab orders.
We recommend Lab Services and Oncology Services continue to research the cause and	A review was performed. EPIC IT team immediately corrected the technical documentation gap	6/11/2024

monitor the process for lab tests being drawn, resulted and billed based on verbal orders without documentation.	ensuring prospectively that verbal/ phone orders are routed to the provider for signature in EPIC.	
We recommend Lab Services reeducate the lab technicians to appropriately route verbal and phone lab orders in Epic to ordering providers for signature prior to drawing and resulting labs.	Ed Peterson will be working with the Lab Directors at West and Regional on the requested action plan.	July 2024
We recommend MPG Business Office retrospectively review Breast Oncology Lab Services for orders signed by a laboratory technician and refund as appropriate.	The business office needs to review the number of transactions and associated dollar impact since the reimbursement is minimal and it is could cost more to review every lab charge. It may cost less money to refund all labs. We need to analyze the data. Refund will be processed in either scenario (meaning refund either true refunds or all labs).	10/31/2024
We recommend MPG Business Office develop, implement, and monitor the process to ensure there is a physician order for DME that contains the quantity to be dispensed if applicable and is delivered to the patient prior to billing.	An IT request for creation of edit will be created to capture DME orders for review.	9/15/2024
We recommend MPG Business Office initiate a retrospective review of DME services to identify charge capture errors and correct and rebill if appropriate.	The affected services are in the process of being identified and corrections or refunds will be performed if appropriate.	9/30/2024
We recommend that MPG physicians ensure that incorrect Open Payments data is disputed and corrected.	The Business Office will coordinate with MCI providers and leadership to correct disputed data.	9/30/2024

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