Memorial Healthcare System

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

DATE: July 31, 2024

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

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

Attached is a copy of the first quarterly report of fiscal year 2025 summarizing the activities of the Internal Audit and Compliance Department from May 1, 2024, through July 31, 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: Dave Smith, Executive Vice President and Chief Financial Officer, MHS
Leah Carpenter, Executive Vice President and Chief Operating Officer, MHS
Vedner Guerrier, Executive Vice President and Chief Transformation Officer, MHS
Aharon Sareli, Executive Vice President and Chief Medical Officer, MHS
Frank Rainer, Senior Vice President and General Counsel, SBHD
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:

- Duties of the Compliance Officer,
- Compliance Working Committee, and
- Reporting of Potential Issues or Areas of Noncompliance.

Revised:

- Direct-to-Consumer Marketing and Patient Waivers of Co-Payments and Deductibles,
- Tobacco and Drug Free Workplace, and
- Disabilities.

II. COMPLIANCE OFFICER

The compliance officer attended the following meetings during the quarter:

- Chief Compliance Officer's Roundtable: One Session,
- HHS Final Rule Implementing Section 504 of the Rehabilitation Act Overview,
- ISACA/IIA Conference - Rise of Artificial Intelligence, and
- FHA Legislative Session Legal and Compliance Roundup: One Session.

III. TRAINING AND EDUCATION

The following compliance training was provided during the quarter:

- New Employee Orientation: Thirteen Sessions
- Leadership Essentials: Two Sessions
- Compliance Working Committee: One Session
- MHW Outpatient Rehabilitation Medicare Documentation: One Session.

IV. OPEN LINES OF COMMUNICATION

A. Hotline Calls

During the quarter, 48 calls, none of which were callbacks, were placed to the System's Compliance Hotline covering 29 new topics and two old topics. Three topics were compliance allegations (three calls). One topic was a HIPAA Privacy allegation (one call). One topic was a larceny allegation (one call). One topic was a workplace safety allegation (one call). All of the calls were investigated and none of the compliance allegations were substantiated.

Finally, two topics were informational (two calls), five topics were uncompleted calls (five calls), and 21 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. 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 16,229, of which 206 reported a possible or potential conflict of interest.

The Conflicts of Interest Subcommittee (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. Seven out of 12 employees have accepted a position on the Subcommittee. The kickoff meeting has been set for October 10, 2024.

VI. RISK ASSESSMENT, MONITORING & AUDITING

VII. RESPONSE & PREVENTION

A. Internal Audit

Recurring Quarterly Reports

South Broward Hospital District Construction Projects

Twenty payment vouchers for 9 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

Nine 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.

Assistance Provided to RSM for Memorial Healthcare System's FY 2024 Audit

Background

As part of the annual financial statement audit, Internal Audit provided audit assistance as directed by our external auditors, RSM US LLP (RSM). Our audit assistance provides the external auditors with professional, in-house knowledge of MHS processes, procedures and systems which improves efficiency in audit testing of internal controls. The purpose of this internal audit report was to summarize the results of the audit assistance provided to RSM for the FY 2024 financial statement audit.

During the interim stage of the audit, we performed walkthrough tests of key business processes including accounts receivable and revenue; cash disbursements; capital assets and property, plant, and equipment (PPE); payroll; inventory; and prepaid expenses. During the interim and final stages of the audit, we also performed substantive testing of samples of payroll; fixed assets and construction in progress (CIP) additions; patient revenue; accounts receivable hindsight; accounts receivable credit balances; accounts receivable zero balance patient accounts; and operating expenses. All walkthrough and substantive test selections were made by RSM.

We provided the final reports, supporting documentation and work papers of the Internal Audit of Credit Cards at Memorial Healthcare System (MHS) and the Investigation of Government Affairs to RSM. In addition, the external auditors requested a report of all payments to MHS credit cards for the period May 2023 to April 2024. RSM then made sample selections and requested supporting documentation for those selections.

Observations

There were no findings or exceptions noted in the walkthrough tests or substantive test of key business processes conducted by Internal Audit. We were not informed of any exceptions in the credit card payment testing performed by RSM.

Recommendations

None.

Consultative Audit of Contract Management at MHS

Background

The contract management function within Memorial Healthcare System (MHS) has historically been the responsibility of the Legal, Risk and Privacy Department (Legal). The Legal Department managed the contract review and draft processes through the MediTract platform from January 2013, through December 2023. MHS transitioned the contract management system from MediTract to Workday in January 2024 to coincide with the implementation of MHS's new Enterprise Resource Planning (ERP) software.

Internal Audit commenced the contract management consultative audit during the early stages of the transition to Workday. During our preliminary discussions with MHS Legal and Supply Chain Management (SCM), we discovered that SCM would be spearheading the new Workday Strategic Sourcing (WSS) contract management platform within the new ERP. We were also told that WSS was not part of the system wide Workday implementation for Finance, Human Capital Management, SCM and Payroll managed by KPMG. Instead, the transition and implementation process to WSS was being managed by SCM in collaboration with Legal with the assistance of Information Technology (IT). To add greater value to the process, Internal Audit pivoted from an internal audit to a consultative role to assess the controls being built into the new Workday contract management platform. The purpose of the audit was to evaluate the design, controls, information security, and performance of the MHS contract management system to determine if it supports MHS's operational and legal objectives and is compliant with The Joint Commission (TJC) standard pertinent to contractual agreements.

We attended design meetings of the WSS; reviewed training literature distributed to MHS contract creators; draft contract routing process flowcharts; minutes of SCM and Legal WSS meetings; WSS test scenarios; reviewed WSS administrator and user roles and permissions; reviewed SCM's assessment of challenges with the MediTract platform and the goals of the new WSS contract management system. We inquired about new policies and procedures for WSS that would replace the existing MHS Standard Practice, *MediTract Policy*. Post implementation, we met with Legal and SCM to discuss issues that became apparent after implementation of the WSS. We solicited feedback from contract creators and Legal on any issues identified with creating contracts for execution in WSS. We provided a summary of those issues to SCM for comments on how they would be addressed moving forward. Finally, we reviewed TJC Standard LD.04.03.09 relevant to contracted services for the provision of care, treatment, and services to patients and reviewed a current MHS contract for compliance. We communicated with the Quality Directors at each MHS hospital to understand the process in place to ensure compliance with Standard LD.04.03.09. We reviewed documentation to support the quality monitoring of clinical vendors.

Observations

We were informed that a new policy would be drafted as soon as the post implementation issues

are resolved. All WSS user roles are based on group permissions and seemed appropriate. In addition, protected service lines such as Physician Employment, Strategic Planning, Corporate Development, and Human Resources have restricted access. Other contract types are only accessible by Legal. Contract creation trainings were deployed prior to the WSS implementation in January 2024, facilitated by SCM and Legal representatives and included live demonstrations in Workday. Prior to contract submission in WSS, contract creators must complete the Contract Background Summary Sheet (CBSS); a Privacy, Data Use, and the Data Security Certification for Contracting Parties form (PHI/PII Certification) and ensure that the vendor has been credentialed. Most of the post implementation issues have been resolved and there is a process in place for end users to report any new issues to SCM and Legal. Our review of the activities of Quality Directors at all MHS hospitals to monitor the performance of clinical vendors revealed consistency in procedures and documentation. Based on the results of our review of the role of MHS Quality Departments and the sample contract reviewed, MHS appears to have procedures in place to be compliant with the requirements of Standard L.D.04.03.09 of the Joint Commission.

Recommendations

We recommended that a new MHS contract management policy is published and distributed. The results of the audit were discussed with Frank Rainer, Senior Vice President and General Counsel, SBHD and Saul Kredi, Vice President, SCM, MHS. Saul Kredi has provided a signed action plan.

Internal Audit Risk Assessment MHS

Background

Memorial Healthcare System (MHS) utilizes its Internal Audit (IA) process to continuously drive value to the organization by focusing IA resources on the entity's top auditable functions. Leveraging the International Professional Practices Framework (IPPF) provided by the Institute of Internal Auditors (IIA), the IA department has adopted a comprehensive risk-based approach to assist in identifying and prioritizing risk types and auditable high-risk areas throughout the organization, by function and entity using a defined risk assessment model specific for MHS.

The objective of this risk assessment was to identify risks throughout MHS requiring IA focus for the 2025 audit plan based on MHS' self-evaluation survey and interviews.

For fiscal year 2025, the following five risk categories were used to assess the potential risk areas for each entity within MHS:

1. Environmental - the ability to adapt to changes created by the government, individuals, technology, regulatory, legal, and/or industry/economic growth.
2. Non-Clinical Compliance and Legal - the ability to comply with laws, rules, and regulations including legal issues.
3. Employee Health/Safety and Satisfaction - the ability to make employees feel safe and to retain employees.
4. Operational and Financial - the ability to maintain the level of infrastructure needed to achieve efficient and effective operations and fiscal management.
5. Fraud and Reputational - the ability to manage fraud or reputational consequences resulting from business activities and/or conduct of management and/or employees.

An open-ended survey with 42 questions regarding the above five risk categories and their potential impact on MHS' operations was distributed to 276 MHS employees. Leaders surveyed were at the Director level and above system wide.

Observations

Ninety-seven (97) surveys were completed; respondents were representative of all MHS facilities and functions. We selected 11 employees (Quality and Patient Safety, Finance, Technology, Facilities, Supply Chain Management, and Human Resources) for follow-up interviews. The objective of those interviews was to further understand current risk concerns and risk trends noted in their responses.

Survey respondents highlighted risks associated with operational burdens due to aging infrastructure and expansion activities; inconsistencies with communication flow from senior leadership with regards to operational and system changes; and access to reliable data and information challenges due to insufficient documentation of data definition. Other areas of concern from respondents included security, workplace violence, and environmental quality related to mold, and water borne infections.

MHS has however implemented mechanisms to mitigate some of the other areas of concerns such as the metal detector pilot program at Memorial Regional Hospital (MRH), an increase in on-site security, and providing staff with de-escalation training and panic buttons for disruptive and violent patients and visitors. With regards to water borne infections, MHS has hired a vendor to remediate the water quality issues. MHS staff will be trained to continue to monitor the remediation process once the contract with the vendor ends.

With regards to potential changes which may occur in the next two to five years, respondents highlighted risks associated with artificial intelligence (AI) and its impact in healthcare and responding to the opportunities to utilize AI to improve workflows and clinical practice; risks surrounding cybersecurity for MHS and its vendors, some vendors not having the necessary resources to adequately address security risks; risks associated with the shift of the Enterprise Project Management Office to the Enterprise Portfolio Management Office to prepare an improved intake process, establish formal prioritization methodologies, and scenario plan to assist the executive team with business decisions. Joint Commission requirements related to decarbonization, and the potential costs associated with going green. Thirteen percent of respondents expressed concern about the loss of institutional knowledge due to retirements, and resignations. IA is currently in the beginning stages of assessing the risks and opportunities of AI.

Recommendations

The following risks are systemwide and will be updated on the IA Audit plan for fiscal year 2025:

1. Cybersecurity: Risks associated with MHS vendors having access to MHS systems and reliance on these vendors for critical services.
2. Construction and Real Estate: Management of future construction expansion projects and the need to maintain aging buildings to the appropriate regulatory and code standards. Assess the management of MHS buildings for general maintenance and air quality issues.
3. Data Validation and Reporting Management: Review completeness of data definitions, assess change management, data validation according to data definitions is performed and documented, and data integrity documentation. Assess whether the data stewardship role is defined and functioning in the organization.
4. Communications: Review communication channels within the organization to ensure information from the executive level is distributed to all levels of staff in a fluid, consistent, and reliable manner.

Internal Audit of Food and Nutrition Services - Purchasing at MHS

Background

Memorial Healthcare System (MHS) Food and Nutrition Services (FNS) Departments are decentralized across all seven facilities, Memorial Regional Hospital (MRH), Memorial Regional Hospital South (MRHS), Joe DiMaggio Children's Hospital (JDCH), Memorial Hospital West (MHW), Memorial Hospital Pembroke (MHP), Memorial Hospital Miramar (MHM), and Memorial Manor Nursing Home (MM). Each FNS department is headed by a FNS Director at each location, Assistant Directors at some locations and are supported by Executive Chefs, kitchen personnel, and Storeroom Clerks. FNS at each location is responsible for food requisitioning, receiving, quality review, credits review, invoice approval, and forwarding invoices to Accounts Payable (AP) for payment. Each location has designated FNS personnel for food ordering, receiving, storing, and order tracking. FNS Directors are solely responsible for food invoice approval in Enterprise Content Management (ECM).

The Food and Nutrition team determines the food required for the facility and generates food orders through email orders, telephone orders, or through the vendor's online ordering portal. The online orders are completed by designated employees and the vendors provide confirmation of orders received. When orders are delivered, the storeroom team verifies the quantity, quality, and completeness of the order. Once verified, the shipping document (if applicable) and/or invoice is forwarded to the FNS Director for approval. Vendors submit invoices to MHS either emailing directly to AP, mailing or leaving hard copies with the food delivery, or through an electronic file upload to ECM. The AP team is responsible for uploading invoices to ECM, creating an approval request and routing to the appropriate approver per the MHS Approval Matrix. The purpose of this audit was to determine whether goods and services for MHS Food Service locations were properly ordered, received, approved and paid for the period May 1 to December 31, 2023.

Observations

All food purchases selected were conducted as non-purchase order (PO)transactions and do not include the electronic three-way matching key control. Each location has appropriate segregation of duties as there are designated FNS staff members for food ordering, receiving, storing, and order tracking. Many vendors use hand-held devices to document proof of delivery and others use receiving documentation that is evidenced by check marks or signatures. We noted 16 invoices without marks or signatures indicating receipt verification. When a Publix credit card is used by a designated for specific purchases that cannot be obtained from other food vendors, receipts are sent to the Supply Chain Management (SCM) representative as an approval to pay. Receipts are held to match to monthly statements, statements are reconciled, the general ledger account number is annotated, and presented to the Director of Supply Chain Business Systems for approval. Invoices are reviewed, authorized, and approved for payment by the FNS Directors. The FNS Directors approval limit is $10,000 according to the Authorization Approval Matrix. US Food Services purchases are not required to obtain further approval for invoices above $10,000 and there is not a policy to support this practice.

Recommendations

We recommended that FNS maintains signed receiving documentation according to the Standard Practice "Records Retention and Disposition Guidelines". We recommended that the FNS approval follow the MHS Approval Matrix with the approvals or document exceptions to the Approval Matrix and include the exception with the Approval Matrix or in the Standard Practice.

The findings of the audit were discussed with the Senior Director, Corporate Finance and the Vice President, Finance. David Smith, Executive Vice President, Chief Administrative Officer and Chief Financial Officer, MHS provided a signed action plan.

Remote Worker Geo-Location and Password Sharing When Connecting to MHS

Background

The Memorial Healthcare System (MHS) remote workforce increased rapidly during the pandemic, and Cisco DUO mobile authentication verified remote connections into the MHS data infrastructure. MHS users are provided with a Citrix Virtual Desktop or Virtual Private Network (VPN) depending on their security level and hardware. Either environment would allow for the remote worker to perform their daily job functions. All remote users are required to register their cell phone and download the Cisco DUO mobile application to provide Two Factor Authentication (2FA). The virtual private network (VPN) environment is granted only if (a) the requesting user is granted such permissions, and (b) the requesting device is MHS owned. If either of those conditions are not met, then the remote session would be a Citrix Virtual Desktop session. Both encrypt data in transit between the remote worker and the MHS network. MHS remote users are not restricted from signing up for any number of VPN services available on the market as a personal security feature on their own devices. When a MHS remote user connects to their own VPN service and then remotely connects to MHS, the connection logging is indistinguishable to any other remote connection. Leveraging marketplace VPN services may unwittingly violate the recently effective Florida Electronic Health Records Exchange Act which requires providers to only store patient data in the continental United States, United States territories or Canada. The purpose of this audit was to evaluate for reasonable geographical location with known and current account accessibility and password controls when remotely logging into MHS and verify that the controls are effective and adhere to policy.

Observations

During the observed period (March 1, 2024, through March 31, 2024), there were eight high volume users with at least 200 unique remote and 101 users with at least 100 unique remote connections to the MHS internal network, but we found that the control feature to disconnect a user from the network for inactivity required the users to log back in. We judgmentally selected five users with physical location mismatch between the 2FA and requestor device. Three of the users had no physical location logged for the 2FA device and did not respond to our communication attempts. Two users had instances logged of the 2FA and requestor devices in two physically separate areas and when contacted, the users verified that they were using a marketplace VPN that masked the requesting device's true location. We found instances of remote connectivity in countries such as Dominican Republic, Nicaragua, Nepal, Guatemala, the Philippines, Israel, Venezuela, Türkiye, and others, but verified that users were either traveling or using marketplace VPN services. We found one user with 18 requesting devices; two users with 19 requesting devices; and one user with 20 requesting devices. With the information currently available to us, we determined that the user had one or two laptops that were moving throughout a facility or to other facilities.

Recommendations

We recommended developing a procedure to investigate users with a high number of remote connections for appropriateness. We recommended users receive education about a marketplace VPN connection matching the 2FA location. We recommended disallowing remote sessions connections in countries MHS deems inappropriate. We recommended developing a process that

can uniquely identify requesting devices. We learned, subsequent to this audit, that MHS Human Resources Department, Legal Department, Privacy Department, and Information Technology Department have formed a committee designed to develop MHS policies specifically targeted to address the remote MHS workforce from a holistic viewpoint.

Jeffrey Sturman, Senior Vice President and Chief Digital Officer agreed with our findings and recommendations and provided a signed action plan.

Follow Up Internal Audit of Memorial Healthcare System Credit Cards

Background

Internal Audit completed an audit of Memorial Healthcare System (MHS) credit cards in January of 2024. There were several findings at the conclusion of that audit that resulted in audit recommendations and a signed Action Plan from MHS leaders. Findings from that audit included the need for a MHS credit card policy; the Medical Affairs credentialing team did not provide supporting documentation for credit card charges when submitting credit card statements for payment; there was no system in place to ensure discontinuation of card usage when an employee is terminated; monthly credit card statements were reviewed and approved by the card holder; and there were missing details for some Government Relations meal charges. We recommended that MHS policy and procedures be developed to establish governance over all MHS credit cards; that supporting documentation be submitted for all charges; and that an independent party review the credit card statements before submission for payment. In addition to the follow up of the audit recommendations, we reviewed the credit card charges, approval and payment for those charges for the period from May 1, 2023, to June 30, 2024. We reviewed gift cards purchases from Publix Supermarket, Inc. through check requests or MHS credit cards for compliance with MHS policies. The purpose of the audit was to review the actions taken on the audit recommendations and assess if those controls are working as designed, review the management of MHS issued credit cards and determine if the controls over credit cards and gift card purchases are adequate to prevent misuse of MHS funds.

Observations

We reviewed the *Memorial Healthcare System Corporate Treasury Policy & Procedures – Policy No. 0015: Corporate Credit Cards* and the *MHS Standard Practice on Gift Cards*. The contents of the new credit card policy have been distributed to current card holders. We were told that all users have signed acknowledgement forms, confirming that they have read the policy. The issue of tracking and discontinuing credit card use after termination of MHS card holders was addressed by the new credit card policy. Corporate Treasury worked with MHS's Information Technology (IT) Department to create a new Periodic Access Review (PAR) credit card notification. This will facilitate quarterly PAR reviews by current MHS primary account cardholders who will be required to review and confirm if authorized MHS credit card users should remain active. In addition, PAR will automatically notify Corporate Treasury when an employee is terminated. Corporate Treasury will then act to deactivate that credit card. Medical Affairs credit card typically has a high volume of credentialing transactions. Those vendors do not generate receipts and line by line match up of charges is almost impossible. Medical Affairs has implemented a compensatory two-step review process. Four of the selections for the follow up audit included charges for Medical Affairs. Selections were appropriately approved and did not include supporting documents with check payment requests. Medical Affairs has requested the assistance of Corporate Treasury to obtain an alternate credit card that offers the flexibility of multiple authorized users, which the Memorial

Employees Financial Credit Union (MEFCU) credit card does not currently accommodate. Five of the 30 credit card payments reviewed included charges made by Government Relations to the Board/Administration MEFCU or to the Government Relations credit card not reviewed in the previous audit. Three of the five check payments had incomplete or no receipts for credit card charges. One of the three which had no supporting documentation was the final credit card payment that closed the Government Relations MEFCU credit card. Two of the 30 check payments included charges made by the Board/Administration and had appropriate supporting documentation. All seven MEFCU credit card payment selections for the Board/Administration/Government Relations were independently reconciled to receipts. Fourteen of the 30 audit selections were check payments to Publix for gift card purchases. We were unable to review Gift Card Distribution Logs for seven of the 14 gift card purchases; one of which was for non-employed, security personnel. All five Sam's Club credit card payments were appropriately approved, independently reviewed, and had the required supporting documentation for those charges.

Recommendations

We recommended that the requirements of the Internal Revenue Service (IRS) with respect to payroll tax deductions for gift cards to employees is monitored to ensure compliance.

Audit findings and recommendation were communicated to Dave Smith, Executive Vice President, Chief Administrative Officer, and Chief Financial Officer, MHS who has provided a signed action plan.

B. Compliance

Compliance Audit of the 340B Program at Memorial Healthcare System - FY 2025 First Quarter

Background

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

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

Observations

Of the 300 pharmacy claims reviewed, there were six claims with ADC overrides for which we were unable to find the provider order in Epic. An ADC override occurs when a clinician pulls medication from the ADC without the pharmacy verifying the order or during emergent situations when the provider may give a verbal order and medication is taken out as an override. In response to previous audit recommendations, Epic Clarity report was developed so pharmacy management can monitor ADC overrides and link them with the provider order within 48 hours. On one of the six claims, we were unable to find the provider order and record of drug administration in Epic but noted a charge when the ADC dispensed the medication. Subsequently, the particular ADC charge settings were updated to prevent a charge from being added to the patient's account when the medication is dispensed and to charge only on administration. In another claim with ADC overrides, a narcotic was given for which we were unable to find the original order in Epic. Pharmacy management noted on review of medical records in Epic that the medication was removed from the ADC and was promptly administered to the patient. Hence, there was no diversion. A written telephone order was obtained but was not signed by the physician nor scanned into the Media file in Epic. According to Health Information Management (HIM), for supplemental paper orders, nursing should have the orders signed by the physician prior to sending them to medical records. As the order was not authenticated by the physician, this claim did not meet 340B eligibility. Additionally, there was one claim with the order written by a provider who was not listed on the credentialed provider's file at the time of drug administration. The patient was seen at our facility for a continuing issue and treatment plan included the medication. Hence, this claim is still 340B eligible as per federal requirements but deviated from the MHS 340B Program Policy.

Recommendations

We recommended the identified 340B ineligible claims be reversed and charges corrected. We recommended the 340B Program and pharmacy management, continue to monitor and review ADC overrides and link them to the provider's order in Epic. We recommended pharmacy management collaborate with nursing management to verify that obtained written orders have the necessary physician signatures and scanned in Epic as part of the medical records when necessary. We recommended the claim with the order written by the inactive provider be amended to reflect the currently approved provider and include the reason for the change.

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

Compliance Audit of Documentation and Billing of Psychiatric Diagnostic Evaluation and Psychotherapy Services Provided in the Outpatient Behavioral Health Center at MRH

Background

Behavioral health services are intended to help diagnose and treat mental health conditions and addiction-related issues. First Coast Service Options, Inc. (FCSO), our Medicare Administrative Contractor, has a Local Coverage Determination (LCD) titled, *Psychiatric Diagnostic Evaluation and Psychotherapy Services* along with referenced article of Billing and Coding. A Psychiatric Diagnostic Evaluation is an integrated biopsychosocial assessment that includes a complete medical history, psychiatric history, a complete mental status exam, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. Psychotherapy is the treatment of mental illness and behavior disturbances through

therapeutic communication and techniques which attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, facilitate coping mechanisms and/or encourage personality growth and development. Psychotherapy services are time-based codes. Start and stop times or total times must be documented.

Memorial Outpatient Behavioral Health Center provides comprehensive mental health and addiction treatment including psychotherapy such as group therapy, individual therapy and family therapy. The purpose of this audit was to determine if documentation supports medical necessity and the accuracy of coding, charging, and billing of psychiatric diagnostic evaluation and psychotherapy services provided in the Outpatient Behavioral Health Center at Memorial Regional Hospital (MRH).

Observations

We reviewed 30 patient accounts with 99 dates of service. All 30 patient accounts had the appropriate diagnosis documented as required by the LCD. Of the 30 accounts, five patients had a Psychiatric Diagnostic Evaluation prior to the selected dates for this audit, twenty-five patient accounts had documentation of Psychiatric Diagnostic Evaluation according to the requirements of LCD. Psychotherapy sessions were provided to patients in 30 patient accounts. Of 99 dates of services, 74 were group or individual therapy. All therapy sessions had the required documentation required by the LCD.

As part of Health Information Management (HIM) function, Epic's Simple Visit Coding (SVC) was implemented to automatically code accounts without coder intervention. Charges for all 99 dates of services were entered by the Behavioral Health Center staff. All twenty-five of the psychiatric diagnostic evaluations which are non-time based CPT codes were charged appropriately. For one of the 25 dates of services the diagnosis documented, and diagnosis code selected by SVC did not concur. The diagnosis code selected by SVC and billed was not to the highest level of specificity documented in the medical record as required by International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) but did not affect reimbursement. All 74 dates of service for therapy sessions had an appropriate diagnosis documented and were charged with the accurate time based Current Procedural Terminology (CPT) codes. Psychotherapy sessions are recurring services that are billed monthly or at the end of treatment. A list of all sessions provided, and all applicable ICD-10-CM diagnoses codes must be included on the claim. In three accounts with 20 dates of services, only one of the diagnosis codes was noted on the bill. SVC's algorithm replaced each date of service diagnosis code with the latest diagnosis documented on the medical record rather than include all applicable diagnosis codes each time charges were entered for different dates of services. Subsequent to this finding, Accounts Receivable Management (ARM) administration requested the Epic team to correct the algorithm and is currently in test environment for assurance. HIM reviewed and corrected the findings and were rebilled by ARM. Twenty-nine accounts were reimbursed and payment for one account was applied to deductible. Patient paid the deductible.

Recommendations

We recommended ARM obtain a sample of Medicare accounts and collaborate with HIM to review the coding after SVC is corrected.

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

Compliance Audit of Documentation and Billing of Spravato (Esketamine) Antidepressant Treatment in the Long-Acting Therapy Clinic at MRH

Background

Depression is a chronic mental health condition often treated with anti-depressant medication. Patients who continue to experience symptoms of depression after appropriate medication therapy with at least two separate antidepressants are considered treatment-resistant depression (TRD). The Food and Drug Administration (FDA) approved Spravato (Esketamine), intranasal for the treatment of adult patients with TRD and depressive symptoms with major depressive disorder (MDD) with acute suicidal thoughts or actions. Spravato is only available through the outpatient healthcare sites enrolled in the FDA Risk Evaluation and Mitigation Strategy (REMS) Program, which focuses on the prevention, monitored and restricted distribution, and the potential for abuse. Outpatient healthcare settings must be certified, and patients must be enrolled in the REMS program prior to the start of treatment. For Spravato, the FDA requires patients be referred by a psychiatrist, take an oral antidepressant medication, and self-administer Spravato under a provider's supervision, and be observed post-administration. A patient assessment with vital signs must be documented prior to medication administration. Spravato should not be administered if blood pressure is above 140/90. Vital signs must be repeated at 40 minutes and at two hours post administration. Monitoring period is at least two hours following each treatment. An assessment to determine that the patient is considered clinically stable to leave the healthcare setting must be documented. Patient monitoring forms must be submitted to the Spravato REMS within seven days for every patient after each treatment session. First Coast Service Options, Inc. (FCSO), our Medicare Administrative Contractor (MAC), has required diagnosis codes that support medical necessity and procedure codes for billing and coding treatment. The Florida Statutes (F.S) chapter 465.1865 enables qualified pharmacists who complete educational requirements to provide patient care services to patients within an established written protocol with the supervising physicians. The Florida Administrative Code (F.A.C) 59G-1.054 requires all Medicaid providers to sign and date each medical record within two business days from the date and time of service. The Long-Acting Therapy (LAT) Clinic at Memorial Regional Hospital (MRH) is a certified Spravato treatment center operating under a collaborative pharmacy practice. Administration and clinical oversight for patient care is provided by a board-certified psychiatrist pharmacist. Patients are referred to the Spravato center by the psychiatrists.

Observations

All five patients had referrals with a diagnosis of TRD or MDD to support medical necessity and were evaluated by the clinical pharmacist for eligibility. We reviewed 53 dates of service (DOS) for all five patient accounts. We noted opportunities for improvement in the documentation for all DOS. We noted 33 of 53 DOS were copied and pasted assessments from a previous visit; the arrival and discharge times documented by the clinical pharmacist and the residents did not concur, and the clinical pharmacist had attestation statement of their own assessment and documentation which is not appropriate. Seven DOS were not documented, signed and dated within two business days as required. Fifteen DOS had the time for pre-medication vital signs documented after the time for medication administration was documented. Fifty-two DOS had medication administration recorded and Spravato was not administered for one DOS. Forty-five out of 52 DOS did not document the vital signs 40 minutes after the dose administration and all 52 DOS had vital signs documented two hours post medication administration. All 52 DOS had documentation of patient education not to drive that day, but documentation indicated patients arrived alone to department and there were no documentation indicating arrangements were made prior to medication administration. All patient monitoring forms were submitted to the Spravato REMS. One DOS was

not charged accurately because Spravato was not administered. Charges for three DOS were not entered by the pharmacist to be billed, but subsequent to this finding, the charges were entered and billed. Forty-nine DOS had the appropriate procedure code charged and billed and thirty had modifier GC appropriately applied to indicate teaching physician services. Twenty-five were not reimbursed. Four Medicare Health Maintenance Organization (HMO) DOS were denied as the primary diagnoses documented were not covered per FCSO article on coding and billing. The remainder of 21 Medicaid HMO DOS denied were reviewed by HIM; four were updated and rebilled by Account Receivables Management (ARM). Seventeen were accurately coded by HIM but not covered by the payor.

Recommendations

We recommended the LAT Clinic with the support of the collaborative psychiatrist educate all on the documentation requirements, develop a process to ensure documentation reflects services provided, prospectively audit a sample of accounts for documentation accuracy, educate all providers on the Centers for Medicare and Medicaid Services (CMS) guideline and documenting the appropriate diagnosis, and develop a process to ensure charges are entered for each date of service.

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

Compliance Audit of Documentation and Billing of the Outpatient Nutrition Program at Joe DiMaggio Children's Hospital

Background

Medical nutrition therapy (MNT) is a nutrition-based examination that includes nutritional diagnostic therapy, counseling and education services for the purpose of managing an acute or chronic condition or disease. MNT service includes an initial assessment and intervention followed by reassessment and intervention encounter(s) provided by a licensed or certified nutrition professional. A physician referral is required. Services are time-based and face-to-face so start and stop times or total times must be documented. Medicaid reimburses MNT services furnished under the direction of a physician, including telemedicine services using at a minimum audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner. Modifier 95 must be used to bill telemedicine and Centers for Medicare and Medicaid Services (CMS) requires a patient consent.

On October 7, 2022, Joe DiMaggio Children's Hospital (JDCH) launched the Outpatient Nutrition Services for pediatric patients with a variety of diagnoses. Administration notified the Compliance and Internal Audit Department of the new program and requested an audit to determine if services provided are medically necessary and supported by documentation and determine the accuracy of coding, charging, and billing of the Outpatient Nutrition Services at JDCH.

Observations

All 30 dates of service had documentation to support medical necessity for the initial assessment and reassessment but did not have start and stop or total time documented as required by Current Procedural Terminology (CPT). The Florida Administrative Code 59G-1.054 "Recordkeeping and Documentation" requires all Medicaid providers to sign and date each medical record within two business days from the date and time of service. Only four of 30 dates of service were documented, signed and dated within two business days as required. We noted the documentation in seven of 30 dates of service were missing height, weight or Body Mass

Index (BMI) percentile which is pertinent for nutrition diagnosis and intervention. Of 30 dates of service, eight documented that it was a telemedicine visit but did not include the required attestation documentation and telemedicine informed consent. Charges for the eight telemedicine visits did not include the appropriate modifier. Four of fifteen dates of service with initial assessment documentation indicated there were referrals from providers but did not have referrals in Epic or uploaded to the media file.

Charges for all 30 dates of services were entered by registered dietitians (RD) and used the correct CPT codes for the initial assessment and reassessment. We were unable to confirm the total units charged and billed as none had start and stop or total time documented. Diagnoses codes for 15 of 30 dates of service were incomplete. The nutrition diagnoses documented for the date of services were either not included or not coded to the highest level of specificity documented in the medical record as required by International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Health Information Management (HIM) corrected coding findings. Seventeen of 30 dates of service were reimbursed but did not have start and stop times or total time documented as required by the CPT. The overpayment was $1996.29. The remaining 13 dates of service were not reimbursed for non-covered services.

Recommendations

We recommended start and stop or total time be documented as required. We recommended all nutrition notes be completed and authenticated within two business days as required by Florida Administrative Code. We recommended all telemedicine visits include the required attestation, telemedicine informed consent and billed with the appropriate modifier. We recommended Outpatient Nutrition Services management develop a process to ensure Medicaid and Medicaid Managed care patients have provider referrals documented in Epic or referral prescriptions are uploaded on the Media file prior to date of service. We recommended Account Receivables Management (ARM) refund the total amount paid for all 17 dates of services if appropriate. We recommended HIM reeducate coders ensure nutrition diagnoses are included and coded to the highest level of specificity documented. We recommended the HIM management audit a sample of Medicaid and Medicaid Managed care accounts for accuracy prospectively. We recommended Reimbursement and Revenue Integrity management collaborate with ARM management to refund retrospectively as appropriate.

Caitlin Stella, Chief Executive Officer and Administrator, JDCH and Ananda Rampat, Chief Financial Officer, JCDH agreed with the audit findings and recommendations and have provided an action plan.

Compliance Audit Risk Assessment

Background

Memorial Healthcare System (MHS) utilizes its compliance audit process to continuously ensure compliance with Federal and State rules and regulations and laws. “Compliance Risk” is a risk of loss resulting from failure to follow an internal policy or requirement, or the failure to follow an external legal requirement, such as a law or regulation, including contractual requirements. An effective Compliance Program implements a regular and systematic identification and assessment of key risk areas. PYA, a healthcare consulting firm, was engaged by MHS to perform an external independent assessment of MHS’s compliance risk (Risk Assessment), which will enable MHS to continue to develop and execute a comprehensive compliance work plan. PYA is a national consulting firm that specializes in regulatory compliance, compensation valuation, and

commercial reasonableness, strategy and integration and reimbursement.

The objective of this risk assessment was to identify compliance risks throughout MHS requiring focus for the fiscal year (FY) 2025 Audit and Compliance Work Plan. There were 18 business areas evaluated, and a risk ranking assigned to 16 risk categories. The 16 risk categories were Behavioral Health, Contract/Vendor Management, Compliance Management, EMTALA, Finance, Grants, Privacy, Quality/Safety, Real Estate/Joint Ventures, Rehabilitation, Research, Revenue Cycle, Strategic Planning, Marketing/Community Outreach/Development, Pharmacy, and Physician Arrangements. Remote interviews were conducted by PYA between June 18, 2024, and July 16, 2024. Interviews encompassed 20 sessions with more than 50 key members of management and leadership. The information provided by interviewees has been aggregated and reported in this assessment. In addition, MHS's organizational structure and Program-related documents were reviewed.

Observations

PYA's examination and ranking of the key risk areas considered the connection to organizational strategy, process complexity and the Office of Inspector General (OIG) and Department of Justice (DOJ) focus areas. All business areas except three received a low risk ranking with recommendations to monitor the processes for reproductive health, enhance collaboration between Quality and Compliance and to monitor activities related to Social Determinants of Health. Three business areas received a moderate risk rating which were Marketing/Community Outreach/Development, Pharmacy, and Physician Arrangements. There were audit opportunities identified for the FY 2025 Audit and Compliance Work Plan in the community partnerships where arrangements are being updated to include a request for items or services in return, drugs received against drugs ordered, anesthesia drug usage, monitoring receipt of patient owned medication against medications charged to the patients, outsourced home infusion billing, and the timesheets review and approval process for medical director and teaching physician services.

PYA reviewed MHS's FY 2025 Audit and Compliance Work Plan and credited it as a comprehensive and risk-based plan. The plan includes high-risk facility billing audits (e.g. 340B, DRG coding, new programs and services, clinical trials, regulatory audits and partnerships with outside parties), professional billing audits (e.g., coding and billing practices of employed physicians), facility and professional billing audits (e.g., medical necessity, coding, and billing audits for MHS and Memorial Physician Group (MPG), and a variety of other compliance audits, such as those scheduled to be performed by outside parties (e.g. property management, physician agreements and price transparency).

Recommendations

Opportunities and recommendations were provided for the FY 2025 Audit and Compliance Work Plan to monitor and audit areas of concern to assist in mitigating risks. It was recommended that audits be conducted to determine current compliance with regulatory and organizational requirements and the results of the audit be incorporated into training sessions and reported to the Audit & Compliance Committee. Although excluded from the scope of the assessment, PYA recommends MHS continue to identify and monitor the use of Artificial Intelligence throughout the organization, develop and implement appropriate policy and procedures, and conduct dynamic audits and monitoring processes for clinical and safety risks as well as performance and privacy issues.

Follow Up Compliance Audit of Remote Cardiac Device Evaluation Services, MPG Professional Coding and Billing

Memorial Healthcare System (Memorial) has contracted with BioBridge/Daniel Benhayon Lanes, MD for a cardiac device data management software solution. These diagnostic services require an order by the treating physician, reported with Current Procedural Terminology (CPT) and the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10–CM) diagnosis code sets on claims. CPT codes are split into remote monitoring (technical component) provided by BioBridge and interpretation and report (professional component) performed by physicians.

Observations

From the previous follow up audit, it was noted that BioBridge no longer qualifies for the sole source exemption. We recommended patient education to include a statement that BioBridge is a MHS physician owned monitoring service, which we were not able to locate in this follow up audit. Medicare considers cardiac device monitoring a diagnostic medical procedure subject to the Anti-Markup Rule and the amount billed should not exceed the acquisition cost. We reviewed 18 accounts and noted six claims indicating anti-markup service for pacemaker monitoring inaccurately submitted the acquisition cost. We reviewed the 18 accounts for medical record documentation, coding, and billing. We noted that six accounts reported CPT codes without medical necessity orders. Information Technology (IT) noted the six accounts had orders placed but had either a no co-sign required note or was pending physician signature. Dr. Benhayon Lanes informed us that patients are only enrolled in BioBridge for monitoring provided the patients have valid medical necessity orders. Two accounts had documentation that supported different CPT codes for the technical component related to the changes in the CMS coding requirements between December 2023, through January 2024. One account had a physician review and interpretation of the monitoring report completed 32 days after the technical component was completed and within two days of the next 30-day monitoring report. As per CPT guidelines, services may not be reported more than once in a 30-day billing cycle. We noted that 11 of the 18 accounts had the date of service (DOS) swapped between technical and professional components on the claim. Upon review, this was found to be associated with an EPIC issue that is being addressed by Clinical Informatics. We were informed by Memorial Physician Group (MPG) Business Office that Epic is replacing the DOS with the date that the charges were released to the revenue system in Epic for both the technical and professional components. The MPG Business Office is working to resolve the issue with IT. None of the 18 accounts reviewed had ICD-10-CM code to indicate the presence of an implanted cardiac device, besides those two accounts had appropriately reported codes and sixteen accounts required additional or different codes. We noted from March 2023 to March 2024, there were 2,210 claim denials for various reasons. All claims are expected to be paid except those denied for registration related issues. BioBridge provides Memorial with monitoring reports for the patient's medical record, a monthly list of all monitored devices for billing, and a monthly invoice to be paid. We noted that BioBridge invoiced Memorial for more device monitoring than were on the monthly billing list. We noted that there is not a reconciliation process to ensure the number of devices monitored on the BioBridge invoice is equal to the number of patient's monitoring reports and the number of monitored devices that we can bill the health plans.

Recommendations

We recommended that the patient education includes informing the patient that the remote monitoring services are provided using a software owned by a Memorial physician and to ensure

that Dr. Benhayon Lanes's patients are informed that BioBridge is his software. We recommended MPG Business office ensure the billing amount not exceed the acquisition cost of the technical component and identify and correct claims with incorrect acquisition amounts retrospectively. We recommended that MPG Business Office correct and rebill or refund accounts as appropriate, and continue ensuring documentation, coding, and billing requirements are met before billing. We recommended reeducation for the physicians, practice users, coders, and billers on orders, medical necessity, DOS, and medical record documentation requirements. We recommended MPG Business Office and the practice users verify appropriate medical necessity orders exist and appropriate DOSs before billing. We recommended that MPG Business Office work with IT to correct the date of service in Epic. We recommended that MPG Business Office provide the front-end practice training on registration focusing on denial prevention. We recommended that MPG Business Office retrospectively review for remote cardiac device monitoring services without orders and refund as appropriate. We recommended that MPG Administration develop, implement, and monitor the invoice reconciliation process for approving payments for BioBridge remote monitoring services.

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 7/31/2024

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	MOB II Third Floor Sports Medicine Thornton Construction Co. Inc. #00148 MHM	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	$ 2,321,339	$ 43,850,159
Prior Change Orders					
Current Change Orders	(394,612)		(261,732)		
Prior Owner Purchase Orders		(180,621)			(9,703,000)
Current Owner Purchase Orders	(6,496)	890			
Current Contract Sum to Date	$ 1,425,469	$ 1,750,211	$ 1,359,239	$ 2,321,339	$ 34,147,159
Previous Payments	209,570	1,749,320	868,999		18,077,715
	5 436,770		4 338,561	1 620,862	15 2,355,292
	6 276,971		5 24,664		16 1,366,209
	7 289,246				17 1,549,574
Total Payments	1,212,557	1,749,320	1,232,224	620,862	23,348,790
Balance	$ 212,911	$ 891	$ 127,015	$ 1,700,477	$ 10,798,369
Owner Purchased Materials					
Retainage	20,034		24,669	23,214	1,215,077
Payments	1,212,557	1,749,320	1,232,224	620,862	23,348,790
Work completed	$ 1,232,592	$ 1,749,320	$ 1,256,894	$ 644,076	$ 24,563,867
Status	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 7/31/2024

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)	
Current Change Orders					
Prior Owner Purchase Orders	(75,607)	(2,591,108)	(750,000)	162,630	(2,705,194)
Current Owner Purchase Orders	(28,307)	108,194		(656,966)	813,248
Current Contract Sum to Date	$ 1,016,393	$ 8,167,503	$ 29,215,826	$ 70,099,682	$ 11,721,167
Previous Payments	975,303	7,479,269	27,791,202	62,807,012	9,774,099
	6 41,090			31 541,999	19 1,572,642
				32 1,079,401	
				33 430,238	
Total Payments	1,016,393	7,479,269	27,791,202	64,858,649	11,346,741
Balance	$ 0	$ 688,234	$ 1,424,624	$ 5,241,034	$ 374,426
Owner Purchased Materials					
Retainage				298,521	154,846
Payments	1,016,393	7,479,269	27,791,202	64,858,649	11,346,741
Work completed	$ 1,016,393	$ 7,479,269	$ 27,791,202	$ 65,157,169	$ 11,501,587
Status	Active	Active	Active	Active	Active

SBHD Construction Projects
Period Ending 7/31/2024

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)		
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	813,314	742,894	2,808,328	6,254,396	87,772,918
4	523,652			15 391,153	
5	75,939			16 384,780	
6	71,892			17 467,720	
Total Payments	1,484,797	742,894	2,808,328	7,498,049	87,772,918
Balance	$ 214,151	$ 999,059	$ 113,525	$ 5,603,665	$ 6,106,416
Owner Purchased Materials					
Retainage	354	39,100		257,903	
Payments	1,484,797	742,894	2,808,328	7,498,049	87,772,918
Work completed	$ 1,485,150	$ 781,993	$ 2,808,328	$ 7,755,952	$ 87,772,918
Status	Active	Active	Active	Active	Active

Memorial Healthcare System
RFP and Competitive Quote Audits

	RFPs	Current Phase - 1st Quarter FY 2025	Audited Through	Exceptions
1	Joint Replacement RFP	Advertising/Mailing	Design	None
2	Janitorial Services RFP	Ranking & Selection	Advertising & Mailing	None
3	Rewards and Recognition RFP	Ranking & Selection	Design	None
4	Contact Center Augmentation RFP	Ranking & Selection	Advertising & Mailing	None
5	Parking Management Service	Analysis	Design	None
6	Employee Survey Tool	Selection	Oral Presentation	None
7	Clinical Engineering Computerized Maintenance Management System	Selection	Oral Presentation	None
8	Compliance Program Evaluation RFP	Cancelled	Oral Presentation	None
9	Merchant Services Processor RFP	Selection	Oral Presentation	None

Memorial Healthcare System
RFP and Competitive Quote Audits

	Completed Competitive Quotes	Amount $	Exceptions
1	Furniture for Family Birth Place MRH	1,280,236	None
2	Pyxis Dispensing Equipment Rental Agreement MHS	1,189,810	None
3	Three Year Agreement for Workforce Management and Healthcare Experience Licenses for Contact Center MHS	674,627	None
4	Three Year Service Agreement for Hemodialysis Equpment MRH and JDCH	552,968	None
5	Three Year Softwared Subscription and Support Agreement for Robotic Process Automation MHS	531,600	None
6	Pharmacy Equipment & Software MHW	474,388	None
7	One Year Rental of Mobile Computed Tomography at Urgent Care Center MHP	455,388	None
8	Fiscal Year 2025 Social Media Target Audience Coverage MHS	429,000	None
9	Patient Medication Specialty Pharmacy MHW	424,000	None
10	Structural Repairs to Visitors and Employee Garage MRH	420,000	None
11	Software Subscription for Clinical Ladder, Peer Review, Nurse Residency Onboarding and Competency Assessment Programs MHS	375,000	None
12	Two Year Subscription to Capital and Supply Guides, Clinical Evidence Assessment Reports, and Workflow Alerts MHS	348,856	None
13	Elevator Modernization at MHP	331,055	None
14	Architectural Programming for Expansion of Memorial Cancer Institute Building at MHW	285,318	None
15	Three Year Service Agreement for Laboratory Equipment MRH	275,615	None
16	Neonatal Intensive Care Unit Wi-Fi Upgrade at JDCH	251,402	None
17	Janitorial Service Agreement Renewal for MHW	239,052	None
18	Neonatal Intensive Care Unit Wi-Fi Upgrade at MRH	210,575	None
19	Epic Migration to Azure Strategy Roadmap MHS	195,000	None
20	Annual Renewal of MHS Public Relations and Communications Scope of Work	192,000	None
21	Replacement of MHS Data Center Firewalls	191,472	None
22	Employee Health Services Construction Project MHS	184,051	None
23	Acute Care Cardiology Equipment Service Agreement JDCH	169,752	None
24	Exterior Waterproofing Repair Project MHM	155,864	None
25	Statement of Work Extension to Develop ServiceNow 360 Platform MHS	149,875	None
26	NeuroInterventional Radiology Equipment for MRH	125,296	None
27	Radio Advertisements Fiscal Year 2025 MHS	118,125	None
28	Maintenance Software Service Agreement to Integrate ServiceNow with Clinical Engineering Department at MHS	106,820	None
29	Five Year Rental and Support for Pyxis Equipment at JDCH	444,550	None
30	Maintenance Agreement Renewal for Radiology Software MHS	196,966	None

Exhibit C

Memorial Healthcare System
Investor Contact Log
Fiscal Year 2025

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

Memorial Healthcare System
Non Audit Engagement Report
Q1 FY 2025

Quarter Ended	RSM US LLP Engagement:		
Q1 FY2025	For professional services rendered and expenses incurred in connection with implementing the GASB 96 Technical subscription based information technology arrangements accounting.	$	27,283
	For professional services rendered and expenses incurred in connection with the preparation of Memorial Healthcare System YE 04/30/2023 tax returns.	$	13,650
	Total	$	40,933
Q1 FY2024	Total spend, provided for comparative purpose	$	22,875

Quarter Ended	Zomma Group LLP Engagement:		
Q1 FY2025	For professional services rendered and expenses incurred in connection with Non Audit Engagements.	$	-
Q1 FY2024	Total spend, provided for comparative purpose	$	-

Memorial Healthcare System

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

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

Date: August 20, 2024

From: Saul Kredi, Vice President SCM, MHS

Subject: **Action Plan: CONSULTATIVE AUDIT OF CONTRACT MANAGEMENT AT MEMORIAL HEALTHCARE SYSTEM**

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 a new MHS contract management policy is published and distributed. This policy should address MHS contract compliance with legal and regulatory requirements and all existing MHS policies.	We will create a new contract management policy in collaboration with Legal to address the process. We will also plan on providing education on the policy and the contract process.	January 31, 2025

cc: K. Scott Wester, President and Chief Executive Officer, MHS
Dave Smith, Executive Vice President, CAO/CFO
Irfan Mirza, Vice President Finance

Memorial Healthcare System

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

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

Date: August 23, 2024

From: David Smith, Executive Vice President, Chief Financial Officer, MHS

Subject: **INTERNAL AUDIT OF FOOD AND NUTRITION SERVICES PURCHASING AT MHS**

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 FNS maintains documentation for the receipt of goods according to the Standard Practice "Records Retention and Disposition Guidelines" which refers to the State of Florida General Records Schedule GS1-SL for State and Local Government Agencies for record retention guidelines.	FNS will speak to all vendors regarding the need to provide receiving documentation according to the Standard Practice.	January 31, 2025
We recommend that the FNS approval follow the MHS Approval Matrix with the email approvals or document exceptions to the Approval Matrix and include the exception with the Approval Matrix or in the Standard Practice.	FNS will work with Corporate Finance and Supply Chain on a method for documenting approval according to the Approval Matrix.	January 31, 2025

cc: Commissioner Elizabeth Justen, Chairwoman, Board of Commissioners, SBHD

Memorial Healthcare System

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

To: Denise DiCesare, Chief Compliance and Internal Audit Officer, MHS
Date: September 26, 2024
From: Jeffrey Sturman, Senior Vice President and Chief Digital Officer, MHS DS
Subject: **Action Plan: REMOTE WORKER GEO-LOCATION AND PASSWORD SHARING WHEN CONNECTING TO MEMORIAL HEALTHCARE SYSTEM**

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 developing a procedure where users who remotely connect a statistically excessive number of times during a specified period are investigated for appropriateness.	MHS will assess excessive logins with the application's inactivity timeout configuration to develop alerts of possible suspicious events.	12-30-2024
We recommend that educational material be generated requesting that remote workers who use a marketplace VPN connect the 2FA and requestor device in the same "physical" location to help remove the appearance of a compromised account.	The Compliance and Internal Audit Department will author and publish a Compliance Connection Newsletter providing education to the MHS workforce. IT Security will also author and publish an awareness about remote access.	04–30-2025

We recommend disallowing remote sessions from taking place in any other country MHS deems inappropriate.	List of currently high risk blocked countries will be reviewed.	11-01-2024
We recommend developing a process that can uniquely identify requestor devices with the same effectiveness as the 2FA Devices.	MHS will assess if current systems can provide additional details than what is already provided about a requesting device or if a new system needs to be purchased.	12-30-2024

cc: Shane Strum, Interim CEO, MHS

Memorial Healthcare System

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

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

Date: September 10, 2024

From: David Smith, Executive Vice President, Chief Administrative Officer, and Chief Financial Officer, MHS

Subject: **FOLLOW UP INTERNAL AUDIT OF MEMORIAL HEALTHCARE SYSTEM CREDIT CARDS**

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

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend that the requirements of the Internal Revenue Service, with respect to payroll tax deductions for gift cards to employees is monitored to ensure compliance.	Sheri Chirgwin, on 9/12/2024, met with the Accounts Payable and Payroll teams to go over the established process. AP will continue to receive and process the check requests for the gift cards. Once cards are received, AP will complete the gift card form, providing the original to the person picking up the cards, keeping a copy on file and emailing a copy to Payroll@mhs.net. The receiver (or department leader) of the cards will complete the log with employee information and gift card numbers. Once cards are distributed, the department will send the completed logs to payroll for processing. Payroll (manager/coordinator) will, on the Thursday preceding Payroll week, will reach out to any leaders/ department owners	In process now 9/12/2024

	listed on open unresolved log forms to ask for the completed log or ETA for the log to be turned in.	

cc: Commissioner Elizabeth Justen, Chairwoman, Board of Commissioners, SBHD

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

Date: August 22, 2024

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

Subject: **Action Plan: COMPLIANCE AUDIT OF THE 340B PROGRAM AT MEMORIAL HEALTHCARE SYSTEM - FY 2025 FIRST QUARTER**

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

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend the identified 340B ineligible claims be reversed and charges corrected.	340B Team to work with Charge Master team to reverse claims	Completed on 8/20/24
We recommend pharmacy management continue to monitor and review Automated Dispensing Cabinet (ADC) overrides and work with nursing leadership to link them to the provider order in Epic.	New override report developed. Pharmacy directors to review workflow for override review at each site 340B Team will continue to target cabinet overrides during monthly audits. Any remaining uncorrected unlinked overrides identified in this ongoing process will continue to have charges reversed and 340B accumulations corrected.	On going
We recommend nursing management to verify that telephone and written orders have the necessary physician signatures and scanned in Epic as part of the medical records, when necessary.	Pharmacy VP to share recommendation with nursing leadership and recommend auditing department to identify a nurse leader for 340B audit action planning	9/30/24
We recommend the claim with the order written by the inactive provider be amended to reflect the currently approved provider and include the reason for the change.	This has been corrected	9/9/24

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

Dorinda Segovia, PharmD
Vice President & Chief Pharmacy Officer

Scott Davis
Vice President, Reimbursement & Revenue integrity

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

Date: June 20,2024

From: Stephen Demmers, Interim Administrator and Chief Executive Officer, MRH
Walter Bussell, Chief Financial Officer, MRH

Subject: **Action Plan: COMPLIANCE AUDIT OF DOCUMENTATION AND BILLING OF PSYCHIATRIC DIAGNOSTIC EVALUATION AND PSYCHOTHERAPY SERVICES PROVIDED IN THE OUTPATIENT BEHAVIORAL HEALTH CENTER AT MEMORIAL REGIONAL HOSPITAL**

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

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend ARM obtain a sample of Medicare accounts and collaborate with HIM to review the coding after Simple Visit Coding is corrected.	ARM will select a random sample of Medicare accounts and send to HIM to confirm coding.	9/30/2024

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

Date: September 27, 2024

From: Stephen Demers, Interim Administrator and Chief Executive Officer, MRH
Walter Bussell, Chief Financial Officer, MRH W Bussell

Subject: **Action Plan: COMPLIANCE AUDIT OF DOCUMENTATION AND BILLING OF SPRAVATO (ESKETAMINE) ANTIDEPRESSANT TREATMENT IN THE LONG-ACTING THERAPY CLINIC AT MEMORIAL REGIONAL HOSPITAL**

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

Recommendations	Response/Action Plan	Estimated Completion Date
We recommend the Long-Acting Treatment (LAT) Clinic management with the support of the Collaborative Psychiatrists educate all providers, including residents, on the documentation requirements of the Florida Administrative Code 59G-1.054 and Centers for Medicare and Medicaid Services (CMS) guidelines.	1. Clinic staff, residents and providers will be educated, (and reeducated annually) to discuss the guidelines and any new changes if applicable. 2. Every year, PGY2 residents will be educated during their didactic period prior to starting their rotation at the LAT clinic during the PGY3 year. All education will be documented utilizing a sign in sheet for each session.	12/31/2024 for all current staff. PGY2s will be educated by June 1st annually (before the start of the PGY3 year).
We recommend the LAT Clinic management develop a process to ensure documentation reflects services provided for each encounter including visit diagnosis, assessments, time for arrival and discharge, vital signs and completeness of note.	The required documentation will be discussed between the pharmacist, resident (as applicable) and provider during each visit. This includes visit diagnosis, assessments, time of arrival and discharge and completion of vitals signs at the designate times per REMS guidelines. The notes will be completed and signed within 24 hours of the time of service.	Ongoing; this will be monitored in the quarterly audits; the first audit will be completed by 1/31/2025.
We recommend the LAT clinic management prospectively audit a sample of Medicare and Medicaid accounts for documentation accuracy.	An audit will be performed quarterly which will include 10% of Medicare and Medicaid patients which were treated with Spravato during that period. The results will be presented in a performance improvement (PI) format and shared with the appropriate parties.	The first audit will be completed by 01/31/2025 (reviewing dates of service from 10/1/24 – 12/31/24)

We recommend the LAT Clinic management educate all providers on the First Coast Service Options, Inc. (FCSO), our Medicare Administrative Contractor article for billing and coding and CMS guideline.	1. Clinic staff, residents and providers will be educated, (and reeducated annually) to discuss the guidelines and any new changes if applicable. 2. Every year, PGY2 residents will be educated during their didactic period prior to starting their rotation at the LAT clinic during the PGY3 year. All education will be documented utilizing a sign in sheet for each session.	12/31/2024 for all current staff. PGY2s will be educated by June 1st annually (before the start of the PGY3 year).
We recommend the LAT Clinic management with support of the collaborative psychiatrists reeducate all providers to document the appropriate diagnosis for each date of service.	The LAT Clinic management will formally reeducate all providers and residents on the importance of documenting the appropriate diagnosis for each date of service at least annually. In addition, the treatment team will discuss the diagnosis during each Spravato encounter to prevent discrepancies.	Ongoing Formal education for current staff will be completed by 12/31/2024
We recommend the LAT Clinic management develop a process to ensure charges are entered for each date of service.	The LAT Clinic management will educate all clinic staff to ensure charges are dropped before signing each encounter. The quarterly audits will ensure this process is followed.	Ongoing Upcoming audit will be completed by 1/31/2025 (reviewing dates of service from 10/1/24 – 12/31/24)

cc: David Smith, Executive Vice President, Chief Administrative Officer and Financial Officer, MHS

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

Date: August 12, 2024

From: Caitlin Stella, Chief Executive Officer and Administrator, JDCH 9-26-24
Ananda Rampat, Chief Financial Officer, JDCH 04252024

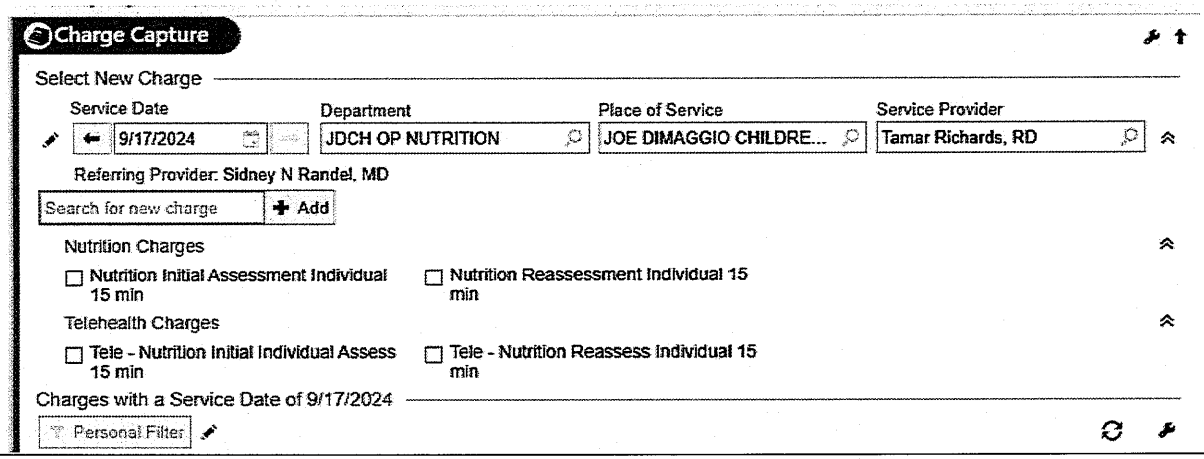
Subject: **Action Plan: Compliance Audit of Documentation and Billing of The Outpatient Nutrition Program at Joe DiMaggio Children's Hospital**

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 start and stop or total time be documented as required by CPT	• Start and stop times have been added in charge capture since May 2024 • In July 2024 we changed process to adding the total time spent or time in and out on notes per Auditor recommendation • IT ticket placed to have "Start time" and "end time" added at the end of the Dietitian note template to force entry Submitted : 09/17/2024 09:57 PM Request Number : **REQ0827604**	9/30/24
We recommend all sections of the nutrition notes be completed and authenticated within two business days as required by Florida Administrative code of	• Effective 8/2024 Dietitian chart notes are being completed on day of service rendered to patients • Management will complete monthly audit to ensure compliance	Completed

record keeping and documentation.		
We recommend all telemedicine visits include the required attestation documentation that includes telemedicine informed consent.	• Effective May 2024, the ".telemedconsent" is being pulled into notes in EPIC. • Management will complete monthly audit to ensure compliance	Completed

We recommend Outpatient Nutrition Services management develop a process to ensure Medicaid and Medicaid Managed care patients have provider referrals documentation in Epic or referral prescriptions uploaded to the Media file in Epic as part of medical record documentation prior to date of service.	• Current process is in place as follows:
	  ○ Patient Access Center schedules appointments, obtains prescription and uploads to media in patient's EMR
	  ○ Pre-Services works the appointments and double checks for Insurance and prescription prior to patient's visit to obtain authorization
	• Confirmed with Patient Access Center Management that all referrals are uploaded into Media Manager in EPIC
	• Request placed for Rightfax/Centralized dedicated fax number for JDCH OP Nutrition.
	Submitted : 09/20/2024 04:10 PM
	Request Number : **REQ0830401**
		10/25/24

We recommend outpatient nutrition management develop a process to include the appropriate modifier for telemedicine charges.	• Patient Access Center makes an appt using the Telehealth codes
	  ○ Telehealth Initial (4547),
	  ○ Telehealth F/U (4548)
	• Dietitians will drop charges in EPIC using Telehealth modifiers below:
	• Registration registers the patients based on the Telehealth appointment scheduled by Patient Access Center
	• Management will complete monthly audit to ensure compliance
	 
		Completed

We recommend ARM refund the total amount paid for all 17 dates of services if appropriate.	• Approved by CFO 9/20/24 • Refund request submitted to Payment Reconciliation Dept	9/30/24
We recommend HIM reeducate coders ensure nutrition diagnoses are included and to code to the highest level of specificity documented as required by ICD-10-CM.	• Will provide re-education of coders at Outpatient Coding Education meeting on 10/15/2024.	10/15/2024
We recommend the HIM management audit a sample of Medicaid and Medicaid Managed care accounts for accuracy prospectively.	• Will audit for accuracy a random sampling of Medicaid and Medicaid Managed Care accounts after education is provided.	12/31/2024
We recommend the Reimbursement and Revenue Integrity management collaborate with ARM management to refund retrospectively to the beginning of the program if appropriate.	• Collaborating with Reimbursement and Revenue Integrity management to identify accounts for review retrospectively.	10/25/24

cc: David Smith, Chief Administrative Officer and Chief Financial Officer, MHS

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

Date: August 6, 2024 [Updated 9/25/24]

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

Subject: **Action Plan: FOLLOW UP COMPLIANCE AUDIT OF REMOTE CARDIAC DEVICE EVALUATION SERVICES, MEMORIAL PHYSICIAN GROUP PROFESSIONAL CODING & 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 the patient education includes informing the patient that the remote monitoring services are provided using a software owned by a Memorial physician and to ensure that Dr. Benhayon Lanes's patients are informed that BioBridge is his software.	Practice Administrators will provide workflow for patient education process. [9/24/24 Update]: Noted that patients are educated at time of consultation when all education occurs. This is documented near the bottom of the note documenting the consult. A sample of the note will be provided for visualization.	10/31/24
We recommend MPG Business office ensure the billing amount not exceed the acquisition cost of the technical component and identify and correct claims with incorrect acquisition amounts retrospectively.	This IT issue has been resolved. The programming was updated in February of 2024	Completed
We recommend that MPG Business Office correct and rebill or refund accounts as appropriate, and continue ensuring documentation, coding,	The business office is unable to manually review every charge prior to billing. We will conduct a quarterly audit of fifty claims per quarter to ensure	Ongoing

and billing requirements are met before billing.	documentation, coding, and billing are appropriate. Audit will be expanded if error rate is >5%. Current findings are that error rate is well under 1%. We'd like to amend this action item.	
We recommend reeducation for the physicians, practice users, coders, and billers on orders, medical necessity, DOS, and medical record documentation requirements.	Two sessions of reeducation occurred. Third session will be scheduled. Because leadership has changed, there is a search for the sign in sheets. If sign in sheets cannot be found, we will provide a letter of attestation of the previous training sessions with new leadership signatures.	12/31/2024
We recommend MPG Business Office and the practice users verify appropriate medical necessity orders exist and appropriate DOS before billing.	The business office is unable to manually review every charge prior to billing. We will conduct a quarterly audit of fifty claims per quarter to ensure medical necessity. Audit will be expanded if error rate is >5%. This is a standard of care for all medical orders at MPG & MHS. Orders are entered annually for BioBridge and documented under the assessment and plan portion of the physician notes. DOS issue has been identified and corrected.	Ongoing
We recommend that MPG Business Office work with IT to correct the date of service in Epic.	In process with IT Dept.	12/31/2024
We recommend that MPG Business Office provide the front-end practice training on registration focusing on denial prevention.	Denial prevention is part of practice operations and provided within overall front-end staff clerical training. We will provide an update to that training by CY end.	12/31/24
We recommend that MPG Business Office retrospectively review for remote cardiac device monitoring services without orders and refund as appropriate.	[9/24/24] Update: Report being built to view orders for BioBridge. Expected ready in October 2024. Once ready, the Business Office and Practice administrators will retrospectively review the remote cardiac device	12/31/24

	monitoring services with intent to find any without orders. If any are found, refunds will be issued.	
We recommend that MPG Administration develop, implement, and monitor the invoice reconciliation process for approving payments for BioBridge remote monitoring services.	Review was completed with Practice Directors. Practice Directors will document the reconciliation process.	12/31/2024

cc: Shane Strum, Interim Chief Executive Officer, MHS