Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COMPLIANCE REVIEW OF THE BROOKLYN HOSPITAL CENTER FOR CALENDAR YEARS 2010 AND 2011

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

James P. Edert
Regional Inspector General

June 2013
A-02-12-01021

Office of Inspector General

https://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis of claims. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

The Brooklyn Hospital Center (the Hospital) is an acute-care hospital located in Brooklyn, New York. Medicare paid the Hospital approximately $116.3 million for 9,097 inpatient and 32,896 outpatient claims for services provided to beneficiaries during calendar years 2010 and 2011 (audit period) based on CMS's National Claims History data.

Our audit covered $987,213 in Medicare payments to the Hospital for 162 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in our audit period and consisted of 125 inpatient and 37 outpatient claims.

OBJECTIVE

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

SUMMARY OF FINDINGS

The Hospital complied with Medicare billing requirements for 27 of the 162 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare

billing requirements for the remaining 135 claims, resulting in overpayments of $544,783 during our audit period. Specifically, 112 inpatient claims had billing errors, resulting in overpayments of $531,663, and 23 outpatient claims had billing errors, resulting in overpayments of $13,120. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $544,783, consisting of $531,663 in overpayments for the incorrectly billed inpatient claims and $13,120 in overpayments for the incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

THE BROOKLYN HOSPITAL CENTER COMMENTS

In its written comments on our draft report, the Hospital concurred with our findings and recommendations and described corrective actions it had taken or planned to take to address them.

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INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.[1] The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.[2] All services and items within an APC group are comparable clinically and require comparable resources.

Hospital Claims at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain hospital claims that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of hospital claims using computer matching, data mining, and analysis of claims. Examples of the types of claims at risk for noncompliance included the following:

[1] In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

[2] HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

- inpatient short stays,
- inpatient hospital-acquired conditions and present-on-admission indicator reporting,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims for blood clotting factor drugs,
- outpatient intensity modulated radiation therapy (IMRT) planning services,
- outpatient claims billed with modifier -59 (indicating that a procedure or service was distinct from other services performed on the same day),
- outpatient claims billed with Doxorubicin Hydrochloride, and
- inpatient and outpatient manufacturer credits for replaced medical devices.

For the purposes of this report, we refer to these areas at risk for incorrect billing as "risk areas."

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." In addition, § 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider.

Federal regulations (42 CFR § 424.5(a)(6)) state that the provider must furnish to the Medicare contractor sufficient information to determine whether payment is due and the amount of the payment.

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, § 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, § 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

The Brooklyn Hospital Center

The Brooklyn Hospital Center (the Hospital) is an acute-care hospital located in Brooklyn, New York. Medicare paid the Hospital approximately $116.3 million for 9,097 inpatient and 32,896 outpatient claims for services provided to beneficiaries during calendar years 2010 and 2011 (audit period) based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

Scope

Our audit covered $987,213 in Medicare payments to the Hospital for 162 claims that we judgmentally selected as potentially at risk for billing errors. These claims had dates of service in our audit period and consisted of 125 inpatient and 37 outpatient claims.

We focused our review on the risk areas that we had identified as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected four claims to focused medical review to determine whether the services were medically necessary.

We limited our review of the Hospital's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by the Hospital for Medicare reimbursement.

We conducted our fieldwork at the Hospital in August and September 2012.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's inpatient and outpatient paid claim data from CMS's National Claims History file for our audit period;
- obtained information on known credits for replaced cardiac medical devices from the device manufacturers for our audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 162 claims (125 inpatient and 37 outpatient claims) for detailed review;

- reviewed available data from CMS's Common Working File for the selected claims to determine whether the claims had been cancelled or adjusted;

- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;

- used CMS's Medicare contractor medical review staff to determine whether four selected claims met medical necessity requirements;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;

- reviewed the Hospital's procedures for assigning HCPCS codes and submitting Medicare claims;

- discussed the incorrectly billed claims with Hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;

- calculated the correct payments for those claims requiring adjustments; and

- discussed the results of our review with Hospital officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

FINDINGS AND RECOMMENDATIONS

The Hospital complied with Medicare billing requirements for 27 of the 162 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 135 claims, resulting in overpayments of $544,783 during our audit period. Specifically, 112 inpatient claims had billing errors, resulting in overpayments of $531,663, and 23 outpatient claims had billing errors, resulting in overpayments of $13,120. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims within the selected risk areas that contained errors. For a detailed list of the risk areas that we reviewed and associated billing errors, see Appendix A.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 112 of 125 selected inpatient claims, which resulted in overpayments of $531,663.

Incorrectly Billed as Inpatient

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

For 108 of 125 selected inpatient claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. The Hospital stated that these errors occurred because Medicare observation criteria was not utilized by Hospital staff. As a result of these errors, the Hospital received overpayments of $512,726.[3]

Incorrect Diagnosis-Related Groups

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Chapter 1, § 80.3.2.2, of the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately …."

For 2 of 125 selected inpatient claims, the Hospital billed Medicare with incorrect DRGs. For one claim, the Hospital incorrectly billed a DRG based on an incorrect primary diagnosis. For the other claim, the Hospital incorrectly billed a DRG based on inadequate documentation of events that occurred prior to admission. The Hospital stated that these errors occurred because Hospital staff misinterpreted coding guidelines. As a result of these errors, the Hospital received overpayments of $7,455.

Lack of Documentation Supporting Services

Section 1815(a) of the Act states: "[N]o such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider … for the period with respect to which the amounts are being paid …."

For 1 of 125 selected inpatient claims, the Hospital billed Medicare for an inpatient stay but was unable to provide documentation supporting the services billed. As a result of this error, the Hospital received an overpayment of $7,210.

[3] The Hospital may be able to bill Medicare Part B for all services (except for services that specifically require an outpatient status) that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient. We were unable to determine the effect that billing Medicare Part B would have on the overpayment amount because these services had not been billed or adjudicated by the Medicare administrative contractor prior to the issuance of our report.

Manufacturer Credit for a Replaced Medical Device Not Obtained

Federal regulations (42 CFR § 412.89(a)) require a reduction in the IPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of the device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device.

Prudent Buyer Principle

Pursuant to 42 CFR § 413.9, "All payments to providers of services must be based on the reasonable cost of services ...." The CMS *Provider Reimbursement Manual* (PRM), part 1, § 2102.1, states:

> Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

Section 2103.A of the PRM further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties for medical devices. Section 2103.C.4 provides the following example:

> Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment supplied.

For 1 of 125 selected inpatient claims, the Hospital did not obtain a credit for a replaced medical device that was available under the terms of the manufacturer's warranty. The Hospital stated that this error occurred because there were no controls in place to identify medical device credits that should have been obtained from the manufacturer. As a result of this error, the Hospital received an overpayment of $4,272.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 23 of 37 selected outpatient claims, which resulted in overpayments of $13,120.

Incorrect Healthcare Common Procedure Coding System Codes

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1,

§ 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately …."

For 20 of 37 selected outpatient claims, the Hospital submitted claims to Medicare with incorrect HCPCS codes. The Hospital incorrectly billed HCPCS code pairs that should not have been reported together. The Hospital stated that these errors occurred because the Hospital's review process was flawed, and did not include the appropriate input from the Clinical Department. The Hospital also stated the staff were inadequately trained on the use of modifiers. As a result of these errors, the Hospital received overpayments of $10,274.

Lack of Documentation Supporting Services

Section 1833(e) of the Act states: "No payment shall be made to any provider of services … unless there has been furnished such information as may be necessary in order to determine the amounts due such provider … for the period with respect to which the amounts are being paid …."

For 2 of 37 selected outpatient claims, the Hospital billed Medicare for outpatient services but was unable to provide documentation supporting the services billed. As a result of these errors, the Hospital received overpayments of $1,217.

Incorrectly Billed Number of Units

Section 1833(e) of the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider. The Manual, chapter 1, § 80.3.2.2, states: "In order to be processed correctly and promptly, a bill must be completed accurately …." The Manual, chapter 17, § 90.2.A, states: "It is … of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug … that was used in the care of the patient." If the provider is billing for a drug, according to chapter 17, § 70, of the Manual, "[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description of the code is 50 mg, and 200 mg are provided, units are shown as 4 …."

For 1 of 37 selected outpatient claims, the Hospital billed Medicare for an incorrect amount of medication administered to the beneficiary. The Hospital stated that this occurred because the Hospital's staff was unaware of coding guidelines. As a result, the Hospital received an overpayment of $1,629.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor $544,783, consisting of $531,663 in overpayments for the incorrectly billed inpatient claims and $13,120 in overpayments for the incorrectly billed outpatient claims, and

- strengthen controls to ensure full compliance with Medicare requirements.

THE BROOKLYN HOSPITAL CENTER COMMENTS

In its written comments on our draft report, the Hospital concurred with our findings and recommendations and described corrective actions it had taken or planned to take to address them. The Hospital's comments are included in their entirety as Appendix B.

APPENDIXES

APPENDIX A: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Inpatient				
Short Stays	117	$556,845	109	$519,936
Hospital-Acquired Conditions and Present-On-Admission Indicator Reporting	6	252,370	2	7,455
Manufacturer Credits for Replaced Medical Devices	2	72,628	1	4,272
Inpatient Totals	**125**	**$881,843**	**112**	**$531,663**
Outpatient				
Claims Billed With Modifier -59	28	$74,440	19	$10,958
Intensity Modulated Radiation Therapy Planning Services	5	21,346	3	533
Claims Billed With Doxorubicin Hydrochloride	4	9,584	1	1,629
Outpatient Totals	**37**	**$105,370**	**23**	**$13,120**
Inpatient and Outpatient Totals	**162**	**$987,213**	**135**	**$544,783**

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient and outpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at the Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

APPENDIX B: THE BROOKLYN HOSPITAL CENTER COMMENTS

The Brooklyn Hospital Center
Keeping Brooklyn healthy.

Lora Myers
VICE PRESIDENT
AUDIT AND COMPLIANCE

May 5, 2013

Report Number: A-02-12-01021

Mr. James P. Edert
Regional Inspector General for Audit Services
HHS Office of Inspector General
26 Federal Plaza, Room 3900
New York, NY 10278

Dear Mr. Edert:

On behalf of The Brooklyn Hospital Center, this letter is in response to the Office of Inspector General audit report entitled "Medicare Compliance Review of The Brooklyn Hospital Center for Calendar Years 2010 and 2011." We concur with the auditors' findings as reported, and the Hospital has developed corrective action plans addressing each of the billing errors, as follows:

Incorrectly billed as inpatient
The audit found that the Hospital incorrectly billed 109 claims to Medicare as inpatient that should have been billed as outpatient or outpatient with observation services. New York State law and regulation (section 405.19 of Title 10 NYCRR) have required hospitals to admit to an inpatient service any patient who has been in the Emergency Department for eight hours. The State is now promulgating regulations providing for the use of observation services, and TBHC is planning to implement a Critical Decision Unit in compliance with those regulations. In the interim, the TBHC Case Management department is utilizing Medicare observation criteria for concurrent admission review of all Medicare short-stay cases.

121 DeKalb Avenue
Brooklyn, NY 11201
Tel:718.250.8458
Fax:718.250.6951
lmyers@nyp.org

Incorrect diagnosis-related groups
For two inpatient claims, the Hospital incorrectly billed a DRG based on an incorrect primary diagnosis. Internal review found that the errors were attributable to misinterpretation of Coding Clinic guidelines by coding staff and inadequate physician documentation to support Present on Admission (POA) assignment. The Hospital has re-educated coding and validation staff, attending physicians, and house staff on POA indicators.

Lack of documentation supporting services
The auditors found one claim for which the Hospital could not provide documentation supporting the services billed. The Hospital reviewed the claim and concurred with the auditors' finding.

Manufacturer credit for replaced medical device not obtained
The auditors identified one claim for which the Hospital had not obtained a credit from the manufacturer for a replaced medical device and did not adjust the inpatient claim accordingly. The Hospital is implementing new software and procedures which will help to ensure that all such device credits are appropriately captured in the future.

Incorrect HCPCS codes
The audit found 19 outpatient claims that had been submitted with incorrect HCPCS codes resulting in overpayment. These were attributable to incorrect use of a modifier indicating that a separate and distinct service had been performed along with the primary procedure billed. The Hospital found that these errors were due to inadequate staff training on the definition and proper use of modifiers. Staff involved in the process has been trained on the use of modifiers using educational materials from CMS; the charge description master and encounter forms have been updated where appropriate; and a written policy and procedure for handling of such claims has been developed.

Lack of documentation supporting services
Two claims involving planning for intensity modulated radiation therapy were incorrectly billed. The Radiology Department has reviewed the incorrect claims and has modified its billing processes to avoid similar errors in the future.

Incorrectly billed number of units
The auditors found one claim for doxorubicin hydrochloride, a chemotherapy agent, which had been billed with the incorrect number of units of the drug. A new encounter form has been developed which requires the nurses to indicate the number of units administered, and the medication administration record is being reconciled on a daily basis.

The Brooklyn Hospital Center takes seriously its obligations to the public and to its patients, including compliance with all law and regulation. We will continue to monitor the corrective actions developed in response to the audit findings. I also want to take the opportunity to commend the OIG audit team for its professionalism and geniality during their time at the Hospital. They were a pleasure to work with.

Sincerely,

/Lora Myers/

cc: Richard B. Becker, MD, President and CEO
Joseph Guarracino, Sr. Vice President and CFO
Elizabeth Bonetti, Asst. Vice President
Evelyn Flores, Revenue Cycle Executive