

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE
REVIEW OF
SAINT LUKE'S HOSPITAL
OF CHESTERFIELD
FOR 2011 AND 2012**

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



**Patrick J. Cogley
Regional Inspector General
for Audit Services**

**August 2015
A-07-14-05063**

Office of Inspector General

<http://oig.hhs.gov/>

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EXECUTIVE SUMMARY

Saint Luke's Hospital of Chesterfield did not fully comply with Medicare requirements for billing outpatient and inpatient services, resulting in overpayments of approximately \$120,000 over more than 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General must provide continual and adequate oversight of Medicare payments to hospitals.

The objective of this review was to determine whether Saint Luke's Hospital of Chesterfield (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification. CMS pays inpatient 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.

The Hospital is a 463-bed acute care hospital located in Chesterfield, Missouri. Medicare paid the Hospital approximately \$197 million for 197,817 outpatient and 14,950 inpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered \$5,871,883 in Medicare payments to the Hospital for 188 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 62 outpatient and 126 inpatient claims. Of the 188 claims, 186 claims had dates of service in CY 2011 or CY 2012, and 2 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010 or CY 2013.

WHAT WE FOUND

The Hospital complied with Medicare billing requirements for 174 of the 188 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 14 claims, resulting in overpayments of \$119,721 for CYs 2011 and 2012 (12 claims) and CYs 2010 and 2013 (2 claims). Specifically, five outpatient claims had billing errors, resulting in overpayments of \$78,002, and nine inpatient claims had billing

errors, resulting in overpayments of \$41,719. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors.

WHAT WE RECOMMEND

We recommend that the Hospital:

- refund to the Medicare contractor \$119,721, consisting of \$78,002 in overpayments for five incorrectly billed outpatient claims and \$41,719 in overpayments for nine incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

Prompted by our review, the Hospital has initiated or completed claims adjustments or cancellation on certain claims.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Hospital agreed with our findings for 12 of the 14 claims that we identified as having been billed in error, and described corrective actions that it had taken or planned to take to further enhance and strengthen its controls.

The Hospital disagreed with our findings on two inpatient claims in which we found that the Hospital should have billed the claims as outpatient or outpatient with observation services. The Hospital stated that both inpatient admissions were medically necessary in accordance with Medicare guidelines and added that it has processes in place for the review of all inpatient claims before discharge to ensure that inpatient status is billed appropriately. The Hospital also said that it would appeal these two claims through the Medicare appeals process.

After reviewing the Hospital's comments, we maintain that all of our findings and the associated recommendations remain valid. We used Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether the inpatient claims with which the Hospital disagreed met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. Based on the contractor's conclusions, we determined, and continue to believe, that the Hospital should have billed the inpatient claims as outpatient or outpatient with observation services.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2012, Medicare paid hospitals \$148 billion, which represents 43 percent of all fee-for-service payments; therefore, the Office of Inspector General (OIG) must provide continual and adequate oversight of Medicare payments to hospitals.

OBJECTIVE

Our objective was to determine whether Saint Luke's Hospital of Chesterfield (the Hospital) complied with Medicare requirements for billing outpatient and inpatient services on selected claims.

BACKGROUND

The Medicare Program

Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

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

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS), which is effective for services furnished on or after August 1, 2000, for hospital outpatient services. 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.¹ All services and items within an APC group are comparable clinically and require comparable resources.

¹ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Hospital Inpatient Prospective Payment System

CMS pays hospital costs at predetermined rates for patient discharges under the inpatient prospective payment system (IPPS). 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 Claims at Risk for Incorrect Billing

Our previous work at other hospitals identified these types of claims at risk for noncompliance:

- outpatient and inpatient manufacturer credits for replaced medical devices,
- outpatient claims with payments greater than \$25,000,
- outpatient and inpatient claims paid in excess of charges,
- outpatient claims with modifiers,
- inpatient DRG verification,
- inpatient claims billed with kyphoplasty services,
- inpatient short stays,
- inpatient claims with payments greater than \$150,000,
- inpatient claims billed with high severity level DRG codes, and
- inpatient claims billed with cancelled elective surgical procedures.

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

Medicare Requirements for Hospital Claims and Payments

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

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

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" (the Social Security Act (the Act), § 1862(a)(1)(A)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

Saint Luke's Hospital of Chesterfield

The Hospital is a 463-bed acute care hospital located in Chesterfield, Missouri. Medicare paid the Hospital approximately \$197 million for 197,817 outpatient and 14,950 inpatient claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$5,871,883 in Medicare payments to the Hospital for 188 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 62 outpatient and 126 inpatient claims. Of the 188 claims, 186 claims had dates of service in CY 2011 or CY 2012, and 2 claims had dates of service in CY 2010 or CY 2013.² We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected nine claims to focused medical review to determine whether the services were medically necessary. 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 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.

See Appendix A for the details of our scope and methodology.

FINDINGS

The Hospital complied with Medicare billing requirements for 174 of the 188 outpatient and inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 14 claims, resulting in overpayments of \$119,721 for CYs 2011 and 2012 (12 claims) and CYs 2010 and 2013 (2 claims). Specifically, five outpatient claims had billing errors, resulting in overpayments of \$78,002, and nine inpatient claims had billing errors, resulting in overpayments of \$41,719. These errors occurred primarily because the Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. For the results of our review by risk area, see Appendix B.

² We selected these two claims for review because the risk area that involves manufacturer credits for replaced medical devices has a high risk of billing errors.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 5 of 62 selected outpatient claims that we reviewed. These errors resulted in overpayments of \$78,002.

Manufacturer Credits for Replaced Medical Devices Not Reported

Federal regulations require a reduction in the OPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device (42 CFR § 419.45). For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device. If the provider receives a replacement device without cost from the manufacturer, the provider must report a charge of no more than \$1 for the device.³

For 5 out of 62 selected claims, the Hospital received full credits for replaced medical devices but did not report the “FB” modifier and reduced charges on its claims. (Of the five claims, one had a date of service in CY 2010, one had a date of service in CY 2011, two had dates of service in CY 2012, and one had a date of service in CY 2013.) The Hospital said that these overpayments occurred because manufacturer reports of device credits were poorly formatted and were not directed to the correct departments to facilitate reporting of the correct modifiers and charges. As a result of these errors, the Hospital received overpayments of \$78,002.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Hospital incorrectly billed Medicare for 9 of 126 selected inpatient claims that we reviewed. These errors resulted in overpayments of \$41,719.

Incorrectly Billed as Inpatient

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” (the Act, § 1862(a)(1)(A)).

According to chapter 1, section 10, of the CMS *Benefit Policy Manual* (Pub. No. 100-02), factors that determine whether an inpatient admission is medically necessary include:

- the severity of the signs and symptoms exhibited by the patient;
- the medical predictability of something adverse happening to the patient;

³ CMS provides guidance on how a provider should report no-cost and reduced-cost devices under the OPPS (CMS Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, § 61.3).

- the need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- the availability of diagnostic procedures at the time when and at the location where the patient presents.

For 3 out of 126 selected claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services. For two of these claims, the Hospital disagreed with our findings. However, the Medicare administrative contractor evaluated the medical necessity requirements associated with these two claims and found that the Hospital had incorrectly billed them. For the remaining claim, the Hospital attributed the overpayment to human error. As a result of these errors, the Hospital received estimated overpayments of \$20,252.⁴

Insufficiently Documented Procedure or Diagnosis Codes

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” (the Act, §1862(a)(1)(A)).

For 5 out of 126 selected claims, the Hospital billed Medicare with incorrectly coded claims that resulted in higher DRG payments to the Hospital. Specifically, certain procedure or diagnosis codes were not supported in the medical records. The Hospital attributed the overpayments to human error. As a result of these errors, the Hospital received overpayments of \$16,967.

Manufacturer Credit for Replaced Medical Device Not Reported

Federal regulations require reductions in the IPPS payments 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 device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost (42 CFR § 412.89). The Manual states that to bill correctly for a replacement device that was provided with a credit, hospitals must code Medicare claims with a combination of condition code 49 or 50, along with value code “FD” (chapter 3, § 100.8).

For 1 out of 126 selected claims, the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claim with the appropriate condition and value codes to reduce payment as required. The Hospital said that this overpayment occurred because manufacturer reports of device credits were poorly formatted and were not directed to the correct departments to facilitate reporting of the correct modifiers and charges. As a result of this error, the Hospital received an overpayment of \$4,500.

⁴ 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 and adjudicated by the Medicare administrative contractor before the issuance of our report.

RECOMMENDATIONS

We recommend that the Hospital:

- refund to the Medicare contractor \$119,721, consisting of \$78,002 in overpayments for five incorrectly billed outpatient claims and \$41,719 in overpayments for nine incorrectly billed inpatient claims, and
- strengthen controls to ensure full compliance with Medicare requirements.

Prompted by our review, the Hospital has initiated or completed claims adjustments or cancellation on certain claims.

AUDITEE COMMENTS

In written comments on our draft report, the Hospital agreed with our findings for 12 of the 14 claims that we identified as having been billed in error, and described corrective actions that it had taken or planned to take to further enhance and strengthen its controls.

The Hospital disagreed with our findings on two inpatient claims in which we found that the Hospital should have billed the claims as outpatient or outpatient with observation services. The Hospital stated that both inpatient admissions were medically necessary in accordance with Medicare guidelines and added that it has processes in place for the review of all inpatient claims before discharge to ensure that inpatient status is billed appropriately. The Hospital also said that it would appeal these two claims through the Medicare appeals process.

The Hospital's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the Hospital's comments, we maintain that all of our findings and the associated recommendations remain valid. We used Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether the inpatient claims with which the Hospital disagreed met medical necessity requirements. The contractor examined all of the medical records and documentation submitted and carefully considered this information to determine whether the Hospital billed the inpatient claims according to Medicare requirements. Based on the contractor's conclusions, we determined, and continue to believe, that the Hospital should have billed the inpatient claims as outpatient or outpatient with observation services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$5,871,883 in Medicare payments to the Hospital for 188 claims that we judgmentally selected as potentially at risk for billing errors. These claims consisted of 62 outpatient and 126 inpatient claims. Of the 188 claims, 186 claims had dates of service in CY 2011 or CY 2012, and 2 claims (involving outpatient and inpatient manufacturer credits for replaced medical devices) had dates of service in CY 2010 or CY 2013 (footnote 2).

We focused our review on the risk areas that we had identified as a result of previous OIG reviews at other hospitals. We evaluated compliance with selected billing requirements and subjected nine 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 outpatient and inpatient 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 audit work from May 2014 to April 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Hospital's outpatient and inpatient paid claim data from CMS's National Claims History file for CYs 2011 and 2012;
- obtained information on known credits for replacement medical devices from the device manufacturers for CYs 2010 through 2013;
- used computer matching, data mining, and other data analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- judgmentally selected 188 claims (62 outpatient and 126 inpatient) 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;

- reviewed the itemized bills and medical record documentation provided by the Hospital to support the selected claims;
- requested that the Hospital conduct its own review of the selected claims to determine whether the services were billed correctly;
- asked Wisconsin Physicians Service Insurance Corporation (the Medicare administrative contractor) to determine whether nine selected claims met medical necessity requirements;
- 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 on April 22, 2015.

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.

APPENDIX B: RESULTS OF REVIEW BY RISK AREA

Risk Area	Selected Claims	Value of Selected Claims	Claims With Over-payments	Value of Over-payments
Outpatient				
Manufacturer Credits for Replaced Medical Devices	12	\$122,886	5	\$78,002
Claims With Payments Greater Than \$25,000	46	1,634,356	0	0
Claims Paid in Excess of Charges	3	20,057	0	0
Claims Billed With Modifiers	1	17,691	0	0
Outpatient Totals	62	\$1,794,990	5	\$78,002
Inpatient				
Diagnosis-Related-Group Verification	61	\$1,800,253	5	\$16,967
Claims Billed With Kyphoplasty Services	3	20,292	2	13,281
Short Stays	8	70,010	1	6,971
Manufacturer Credits for Replaced Medical Devices	1	8,957	1	4,500
Claims With Payments Greater Than \$150,000	6	1,040,864	0	0
Claims Billed With High Severity Level Diagnosis-Related-Group Codes	35	854,563	0	0
Claims Paid in Excess of Charges	11	279,944	0	0
Claims Billed With Cancelled Elective Surgical Procedures	1	2,010	0	0
Inpatient Totals	126	\$4,076,893	9	\$41,719
Outpatient and Inpatient Totals	188	\$5,871,883	14	\$119,721

Notice: The table above illustrates the results of our review by risk area. In it, we have organized outpatient and inpatient 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 C: AUDITEE COMMENTS



July 2, 2015

Report Number: A-07-14-05063

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Dear Mr. Cogley,

St. Luke's Hospital is in receipt of the Office of Inspector General's (OIG) draft report entitled *Medicare Compliance Review of Saint Luke's Hospital of Chesterfield for 2011 and 2012*. The objective of this review was to determine if St. Luke's Hospital complied with Medicare requirements for billing outpatient and inpatient services on selected claims for calendar years 2011 and 2012.

Each of the OIG's findings and St. Luke's corresponding responses are addressed as follows:

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

The OIG found that St. Luke's incorrectly billed Medicare for 5 of 62 selected outpatient claims reviewed, resulting in overpayments of \$78,002. The Hospital received full credits for replaced medical devices but did not report the "FB" modifier and reduce charges on its claims.

Manufacture Credits for Replaced Medical Devices Not Reported:

St. Luke's agrees with the OIG's findings. Our internal process for receiving and communicating medical device credits to the appropriate departments has since been strengthened and monthly reports from device manufacturers/vendors have been requested to assist in early identification of any credits.

Corrected claims are in the process of being resubmitted with the appropriate condition codes and overpayments refunded to Medicare. St. Luke's is also reviewing claims with medical device credits not reviewed by the OIG in this audit to ensure correct billing.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The OIG found that the St. Luke's incorrectly billed Medicare for 9 of 126 selected inpatient claims reviewed, resulting in overpayments of \$41,719.

Incorrectly Billed as Inpatient:

The OIG found that the Hospital incorrectly billed Medicare Part A for 3 of 126 selected claims reviewed for inpatient stays that should have been billed as outpatient or outpatient with observation services, resulting in estimated overpayments of \$20,252.

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St. Luke's agrees with the OIG's findings on one of the three claims. A corrected claim has been submitted with the appropriate patient status and overpayments refunded to Medicare.

St. Luke's disagrees with the OIG's findings on the remaining two claims and will appeal both through the Medicare appeal process. Both inpatient admissions were medically necessary in accordance with Medicare guidelines.

St. Luke's has processes in place for review of all inpatient claims prior to discharge to ensure inpatient status is billed appropriately.

Insufficiently Documented Procedure or Diagnosis Codes:

The OIG found that the Hospital billed Medicare incorrectly for 5 of 126 claims reviewed resulting in higher DRG payments and overpayments of \$16,967. Specifically, certain procedure or diagnosis codes were not supported in the medical records.

St. Luke's agrees with the OIG's findings. These coding errors were the result of human error. Corrected claims were resubmitted and overpayments refunded to Medicare. St. Luke's coding staff also received additional focused education and training.

Manufacturer Credit for Replaced Devices Not Reported:

The OIG found that for 1 of 126 selected claims, the Hospital received a reportable medical device credit from a manufacturer but did not adjust its inpatient claim with the appropriate condition and value codes to reduce payment as required, resulting in an overpayment of \$4,500.

St. Luke's agrees with the OIG's findings. Our internal process for receiving and communicating medical device credits to the appropriate departments has since been strengthened and monthly reports from device manufacturers/vendors have been requested to assist in early identification of any credits.

A corrected claim has been resubmitted with the appropriate condition and value codes. St. Luke's is also reviewing claims with medical device credits not reviewed by the OIG in this audit to ensure correct billing.

St. Luke's Hospital is committed to compliance with Medicare rules and billing regulations. We appreciate the opportunity to review these claims and correct any errors identified, and will continue to strengthen our internal controls.

Please do not hesitate to contact me directly at 314-205-6515 with any questions.

Sincerely,



Charla Craig, CHC, CHPC, CPHRM
Compliance Officer and Director Risk Management & Corporate Compliance
St. Luke's Hospital
232 S. Woods Mill Road
Chesterfield, MO 63017