Report in Brief
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Hospital Provider Compliance Audit: St. Joseph's Hospital Health Center

Why OIG Did This Audit

This audit is part of a series of hospital compliance audits. We selected St. Joseph's Hospital Health Center (the Hospital) for a compliance audit through the use of computer matching, data mining, and data analysis techniques, and in consultation with another OIG component that categorized the Hospital as being a high risk for noncompliance based upon its refusal to enter into a Corporate Integrity Agreement after settling two False Claims Act cases.

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

How OIG Did This Audit

Our audit covered about $50 million in Medicare payments to the Hospital for 9,742 claims that were potentially at risk for billing errors. We selected for audit a stratified random sample of 75 inpatient and 25 outpatient claims with payments totaling $1.4 million for our 2-year audit period (July 1, 2017, through June 30, 2019).

We focused our audit on the risk areas that we identified as a result of prior OIG audits at other hospitals and an OIG analysis of the Hospital's Medicare inpatient and outpatient claims. We evaluated compliance with selected billing requirements and submitted records associated with them to a medical review contractor.

What OIG Found

The Hospital complied with Medicare billing requirements for 94 of the 100 inpatient and outpatient claims we audited. However, the Hospital did not fully comply with Medicare billing requirements for the remaining six claims, resulting in overpayments of $68,897 for the audit period. Specifically, five inpatient claims and one outpatient claim had billing errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $389,000 for the audit period. As of the publication of this report, this amount included claims outside of the Medicare 4-year claim-reopening period.

What OIG Recommends and Hospital Comments

We recommend that the Hospital: (1) refund to the Medicare contractor $389,000 in estimated overpayments for the audit period for the claims that it incorrectly billed that are within the 4-year claim reopening period; (2) based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and (3) strengthen controls to ensure full compliance with Medicare requirements. The detailed recommendations are listed in the body of the report.

In written comments on our draft report, the Hospital partially disagreed with our first recommendation, stated that it complied with our second recommendation, and contended that it did not need to implement our third recommendation. Additionally, the Hospital took issue with our sampling and estimation methods.

After reviewing the Hospital's comments, we maintain that our findings and recommendations are valid. We carefully considered the Hospital's comments on our sampling and estimation methods, and we maintain that our statistical approach resulted in a statistically valid and reasonably conservative estimate of the amount overpaid by Medicare to the Hospital. While the Hospital believes it complied with the 60-day rule and contends that it does not need additional internal controls, we disagree with the Hospital's assertion that it complied with its obligation to repay claims pursuant to this rule and maintain that it should strengthen its controls to ensure compliance with Medicare requirements.

The full report can be found at https://oig.hhs.gov/oas/reports/region2/22001004.asp.