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

Medicare Hospital Provider Compliance Audit: Forbes Hospital

Why OIG Did This Audit

This report is part of a series of hospital compliance audits. 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) 2017, Medicare paid hospitals $206 billion, which represents 55 percent of all fee for service payments for the year; accordingly, it is important to ensure that hospital payments comply with requirements.

Our objective was to determine whether Forbes Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims in CYs 2016 and 2017.

How OIG Did This Audit

Our audit covered $10.6 million in Medicare payments to the Hospital for 817 claims that were potentially at risk for billing errors.

We selected for review a stratified random sample of 100 claims with payments totaling $1.7 million. Medicare paid these 100 claims, which consisted of 92 inpatient and 8 outpatient claims, during CYs 2016 and 2017.

We focused our audit on the risk areas that we identified during previous OIG audits at other hospitals. We evaluated compliance with selected billing requirements.

What OIG Found

The Hospital complied with Medicare billing requirements for 51 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 49 claims, all of which were inpatient, resulting in overpayments of $590,646 for CYs 2016 and 2017.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $3.3 million for CYs 2016 and 2017.

What OIG Recommends and Hospital Comments

We recommended that the Hospital (1) refund to the Medicare contractor $3.3 million ($590,646 in net overpayments identified in our sample) in estimated overpayments for incorrectly billed claims that are within the reopening period; (2) based upon 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 returned overpayments as having been made in accordance with this recommendation; and (3) strengthen controls to ensure full compliance with Medicare requirements by ensuring that all inpatient rehabilitation facility beneficiaries meet Medicare criteria for acute inpatient rehabilitation, ensuring that all inpatient beneficiaries meet Medicare criteria for inpatient hospital services, ensuring that the procedure and diagnosis codes used are supported by the medical records, and ensuring that the codes used for distinct procedural services are supported by the medical records.

The Hospital disagreed with our findings and recommendations regarding incorrectly billed and incorrectly coded claims. The Hospital also disagreed with our use of extrapolation and our recommendation that it identify, report, and return any additional similar overpayments received outside of the audit period. In addition, the Hospital stated that it has a compliance program, ongoing Hospital monitoring, and system-wide management meetings under physician leadership.

We obtained independent medical review for all inpatient and outpatient claims in our sample. We provided the independent medical reviewers with all documentation necessary to sufficiently determine medical necessity and coding for all inpatient claims, and our report reflects the results of that review. Our statistical methods have been fully explained and repeatedly validated. Therefore, we maintain that all of our findings and recommendations are correct.

The full report can be found at https://oig.hhs.gov/oas/reports/region3/31800005.asp.