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

Medicare Compliance Review of Carolinas Medical Center

Why OIG Did This Review

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and other data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2015, Medicare paid hospitals $163 billion, which represents 46 percent of all fee-for-service payments to hospitals.

The objective of this review was to determine whether Carolinas Medical Center (the Hospital) complied with Medicare requirements for billing inpatient services on selected types of claims.

How OIG Did This Review

We selected for review a stratified random sample of 240 claims with payments totaling $3.1 million for our audit period.

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.

What OIG Found

The Hospital complied with Medicare billing requirements for 157 of the 240 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 83 claims, resulting in net overpayments of $331,831 for our audit period from January 1, 2014, through December 31, 2015. 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.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $1.7 million for the audit period.

What OIG Recommends and Hospital Comments

We recommend that the Hospital refund to the Medicare program $1.7 million in estimated overpayments for the audit period for claims that it incorrectly billed; exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day repayment rule, and identify any returned overpayments as having been made in accordance with this recommendation; and strengthen controls to ensure full compliance with Medicare requirements.

The Hospital disagreed with our disallowance determinations on certain claims, and contended that the extrapolation of our results was invalid. The Hospital stated that, in accordance with the 60-day rule, it had identified and is refunding for one finding similar overpayments for claims outside of our audit period. However, it did not address whether it planned to do this for other claims it billed incorrectly, other than stating that it had reached out to CMS on one disputed finding. Also, the Hospital stated that it had a strong compliance program and has developed comprehensive policies, procedures, education, auditing, and other initiatives to improve its programs and acknowledged the importance of continuing improvements in compliance efforts.

After reviewing the Hospitals comments, we maintain that our findings and recommendations are valid. We used an independent medical reviewer to determine whether certain sampled claims were appropriately billed. Additionally, we used valid statistical sampling methodology in our sample selection and in determining the estimated Medicare overpayment.