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

Medicare Compliance Review of WakeMed Raleigh Campus

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 2016, Medicare paid hospitals $170 billion, which represented 46 percent of all fee-for-service payments to hospitals.

The objective of this review was to determine whether WakeMed Raleigh Campus (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 263 claims with payments totaling $3.2 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 187 of the 263 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 76 claims, resulting in net overpayments of $249,954 for our audit period from September 1, 2014, through August 31, 2016. 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 $697,608 for the audit period.

What OIG Recommends

We recommend that the Hospital refund to the Medicare program $697,608 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 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.

In written comments on our draft report, the Hospital disagreed with our findings on certain claims and contended that the extrapolation of our results was not justifiable or appropriate. The Hospital also disagreed with any suggestion that the audit results demonstrate deficiencies in its key controls for coding, billing, and documenting within the medical records. The Hospital stated that it would continue to assess its obligations under the 60-day rule and conduct any necessary expanded review within the time limits established under the program requirements.

After reviewing the Hospital's 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 a statistically valid sampling methodology in our sample selection and in determining the estimated Medicare overpayment.