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

Medicare Compliance Review of Community Hospital

Why OIG Did This Review

This review is part of a series of hospital compliance reviews. Using computer matching, data mining, and data analysis techniques, we assessed hospital claims based on risk for noncompliance with Medicare billing requirements. For calendar year 2017, Medicare paid hospitals $206 billion, which represents 55 percent of all fee-for-service payments for the year.

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

How OIG Did This Review

We selected for review a stratified random sample of 170 inpatient and outpatient claims with payments totaling $2.8 million for our audit period.

We focused our review on the risk areas that we had identified during prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements.

What OIG Found

The Hospital complied with Medicare billing requirements for 84 of the 170 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 86 claims, all of which were inpatient, resulting in net overpayments of $1,266,758 for calendar years 2015 and 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 $22 million for our audit period.

What OIG Recommends

We recommend that the Hospital refund the Medicare contractor $22 million (of which $1,266,758 was net overpayments identified in our sample) 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 strengthen controls to ensure full compliance with Medicare requirements.

In written comments on our draft report, the Hospital generally disagreed with our findings and recommendations. The Hospital agreed that for some claims in the sample, the documentation supports a different level of reimbursement. The Hospital believed that the OIG had no apparent reason to select them for audit, disagreed with all of the findings on the inpatient rehabilitation claims reviewed and believed that we applied the wrong standards, and stated that OIG's sampling methodology was flawed and our use of extrapolation was inappropriate and premature.

After review and consideration of the Hospital's comments, we maintain that all of our findings and the associated recommendations are valid. We submitted the claims selected for review to an independent medical review contractor who reviewed the medical record in its entirety to determine whether the services were medically necessary and provided in accordance with Medicare coverage and documentation requirements.

The use of statistical sampling to determine overpayment amounts in Medicare is well established and has repeatedly been upheld on administrative appeal within the Department and in Federal courts.