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

Medicare Hospital Provider Compliance Audit: St. Francis Hospital

Why OIG Did This Audit

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

Our objective was to determine whether St. Francis Hospital (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 $44 million in Medicare payments to the Hospital for 3,192 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 100 claims with payments totaling $1.6 million for our audit period (January 1, 2016, through December 31, 2017).

We focused our audit on the risk areas identified because of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements.

What OIG Found

The Hospital complied with Medicare billing requirements for 86 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 14 claims, resulting in overpayments of $204,265 for the audit period. Specifically, 11 inpatient claims had billing errors, resulting in overpayments of $203,524, and 3 outpatient claims had billing errors, resulting in overpayments of $741. 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 $1.6 million for the audit period.

What OIG Recommends and Hospital Comments

We recommend that the Hospital refund to the Medicare contractor $1.6 million in estimated overpayments for the audit period for claims that it incorrectly billed that are within the reopening period; 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 strengthen its controls to ensure full compliance with Medicare requirements.

In written comments on our draft report, the Hospital disagreed with most of our findings and recommendations. The Hospital agreed with 6 of the 14 payment errors identified in the sample. However, the Hospital disagreed with: OIG's determination of eight IRF payment errors in the sample; OIG's extrapolation methodology; and the application of the 60-day rule.

After review and consideration of the Hospital's comments, we maintain that our findings and the associated recommendations are valid. The use of statistical sampling to determine overpayment amounts in Medicare is well established and has repeatedly been upheld on appeal in Federal courts. An independent medical review contractor, employing licensed health professionals with appropriate medical expertise, including physicians with training and expertise in rehabilitation, determined whether the medical records supported Medicare payments. We also maintain that the 60-day repayment rule is applicable.