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

Medicare Hospital Provider Compliance Audit: Saint Francis Health Center

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 2016, Medicare paid hospitals $170 billion, which represents 46 percent of all fee-for-service payments for the year.

Our objective was to determine whether Saint Francis Health Center (the Hospital) complied with Medicare requirements for billing inpatient services on selected types of claims from January 1, 2015, through December 31, 2016.

How OIG Did This Audit

We selected for review a stratified random sample of 100 inpatient claims with payments totaling $1.4 million for our 2-year audit period.

We focused our audit on the risk areas identified as a result of prior OIG audits at other hospitals. We evaluated compliance with selected billing requirements and referred each sampled claim to medical review to determine whether the claim was supported by the medical record.

What OIG Found

The Hospital complied with Medicare billing requirements for 49 of the 100 inpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 51 claims, resulting in overpayments of $707,118 for calendar years 2015 and 2016.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $5.5 million for the audit period.

What OIG Recommends and Hospital Comments

We recommend that the Hospital refund to the Medicare contractor $5.5 million of the estimated overpayments for the claims incorrectly billed that are within the Medicare reopening period; for the remaining portion of the estimated $5.5 million overpayment for claims that are outside of the Medicare reopening period, exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; exercise reasonable diligence to identify and return any additional similar overpayments 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.

The Hospital agreed that four of the nine inpatient claims that we found to be in error were incorrectly coded. The Hospital disagreed with the remainder of our findings, including our extrapolated overpayment and our recommendations. The Hospital stated that our independent medical review contractor committed numerous errors when making its determinations.

We asked our contractor to review the Hospital's comments and the supplemental documentation that it provided. Based on the results of this additional medical review and our evaluation, we revised our determinations, adjusting the total number of reportable error claims in our audit period from 53 to 51, and revised our findings and the associated recommendations accordingly. We maintain that our remaining findings and recommendations are valid. Our contractor examined all of the material in the medical records and the documentation submitted by the Hospital, applied relevant criteria, and reached carefully considered conclusions. In addition, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.