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

Medicare Hospital Provider Compliance Audit: Alta Bates Summit Medical Center

Why OIG Did This Audit

This audit is part of a series of hospital compliance audits. Using computer matching, data mining, and data analysis techniques, we identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2018, Medicare paid hospitals $179 billion, which represents 47 percent of all fee-for-service payments for the year.

Our objective was to determine whether Alta Bates Summit Medical Center (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 $31 million in Medicare payments to the Hospital for 1,072 claims that were potentially at risk for billing errors. We selected for review a stratified random sample of 85 inpatient and 15 outpatient claims with payments totaling $4 million for our 2-year audit period (January 1, 2017, through December 31, 2018).

We focused our audit on the risk areas that we identified as a result 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 54 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 46 claims, resulting in overpayments of $1.6 million for the audit period. Specifically, 45 inpatient claims and 1 outpatient claim had billing errors.

On the basis of our sample results, we estimated that the Hospital received overpayments of approximately $16.4 million for the audit period. During the course of our audit, the Hospital submitted four of these claims for reprocessing, and we verified those claims as correctly reprocessed. Accordingly, we have reduced the recommended refund by $49,118.

What OIG Recommends and Hospital Comments

We recommend that the Hospital refund to the Medicare contractor $16.3 million ($16.4 million less $49,118 that the Hospital has already repaid) 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 disagreed with most of our findings and recommendations. The Hospital disagreed with the inpatient rehabilitation facility claims that we identified as incorrectly billed, highlighting the claims that were documentation errors. In addition, the Hospital disagreed with OIG's extrapolation, audit timing, and methodology. Furthermore, the Hospital disagreed with 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 correct. We submitted the claims selected for review to an independent medical review contractor that reviewed the medical records in their 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 appeal in Federal courts. Regarding the Hospital's claim that the 60-day repayment rule is not applicable to specific claims, we maintain that our findings are correct and that this audit report constitutes credible information of potential overpayments.

The full report can be found at https://oig.hhs.gov/oas/reports/region4/41908071.asp.