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

Medicare Hospital Provider Compliance Audit: St. Vincent Hospital

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 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 St. Vincent Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

How OIG Did This Audit

We selected for audit a stratified random sample of 135 inpatient and 10 outpatient claims with payments totaling $3.2 million for our 2-year audit period (January 1, 2016, through December 31, 2017).

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 87 of the 145 inpatient and outpatient claims we audited. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 58 claims, resulting in net overpayments of $293,404 for the audit period. Specifically, 49 inpatient claims had billing errors, resulting in overpayments of $284,753, and 9 outpatient claims had billing errors, resulting in overpayments of $8,651.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $2.1 million for the audit period.

What OIG Recommends and Auditee Comments

We recommend that the Hospital refund to the Medicare contractor $2.1 million in estimated overpayments for incorrectly billed services; 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. The detailed recommendations are included in the body of the report.

In written comments on our draft report, the Hospital generally disagreed with our findings and recommendations. The Hospital agreed with some of the errors in the sample and stated that corrective actions were underway and, in most cases, complete. The Hospital disagreed with the OIG findings for all 16 errors related to the Incorrectly Billed as Inpatient and Inpatient Rehabilitation Facility risk areas. The Hospital stated that the medical necessity criteria were met in all cases and plans to appeal these findings. The hospital agreed with the 60-day recommendation as it related to 3 error categories.

We maintain that all our findings and the associated recommendations are valid. We submitted these claims to a focused medical review to determine whether the services met medical necessity and coding requirements. Each denied case was reviewed by two clinicians, including a physician. We stand by those determinations.