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

Medicare Hospital Provider Compliance Audit: Flagstaff 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 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 Flagstaff Medical Center (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 review a stratified random sample of 90 inpatient and 10 outpatient claims with payments totaling $2.6 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 97 of the 100 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining three claims, resulting in overpayments of $79,216 for the audit period.

On the basis of our sample results, we estimated that the Hospital received overpayments of at least $79,216 for the audit period.

What OIG Recommends and Auditee Comments

We recommended that the Hospital: refund to the Medicare contractor $79,216 in estimated overpayments for the audit period for claims that it incorrectly billed; based on the results of this audit, 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 controls to ensure full compliance with Medicare requirements.

The Hospital concurred with our second and third recommendations but did not entirely concur with our first recommendation. The Hospital agreed that it inappropriately billed three of the six claims that our draft report had identified as errors and stated that it had implemented additional education and controls to prevent similar mistakes in the future. The Hospital disagreed that the other three claims that our draft report had identified as errors represented overpayments. The Hospital gave us documentation that it believed would support the appropriateness of these three claims and said that they were appropriately billed and paid.

Based on the results of additional medical review performed by our independent medical review contractor as well as our evaluation of the Hospital's written comments and its additional and supplemental documentation, we revised our determinations for this final report. Specifically, we adjusted the total number of claims identified as errors in our audit period from six to three and revised our findings and the associated dollar amount in our first recommendation accordingly. We maintain that these three remaining findings—which the Hospital agreed were billed in error—and our revised recommendations are valid.