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

Medicare Compliance Review of Rush University Medical Center

Why OIG Did This Review

This review is part of a series of hospital compliance reviews. 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 2015, Medicare paid hospitals $163 billion, which represents 46 percent of all fee-for-service payments for the year.

Our objective was to determine whether Rush University Medical Center (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

How OIG Did This Review

We selected for review a stratified random sample of 120 inpatient and outpatient claims with payments totaling $1.7 million for our audit period.

We focused our review on the risk areas that we had identified during prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements.

What OIG Found

The Hospital complied with Medicare billing requirements for 63 of the 120 inpatient and outpatient claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 57 claims, resulting in overpayments of $814,150 for calendar years 2014 and 2015. Specifically, 51 inpatient claims had billing errors, resulting in overpayments of $812,744, and 6 outpatient claims had billing errors, resulting in overpayments of $1,406. 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 approximately $10.2 million for our audit period.

What OIG Recommends and Auditee Comments

We recommend that the Hospital refund to the Medicare contractor $10.2 million (of which $814,150 was overpayments identified in our sample) 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 identify any returned overpayments as having been made in accordance with this recommendation; and strengthen controls to ensure full compliance with Medicare requirements.

In written comments on our draft report, the Hospital generally disagreed with our findings and recommendations. The Hospital agreed that for some claims in the sample, the documentation supports a different level of reimbursement. The Hospital disagreed with more than half of the findings on the inpatient rehabilitation claims reviewed and said that it believes the error rate to be much lower than what OIG claims. The Hospital also stated that it did not have a sufficient understanding of OIG's sample methodology to confirm OIG's extrapolated amount or to offer an alternative amount.

We maintain that all of our findings and the associated recommendations are valid. We subjected 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