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OIG Audit: Community Hospital Was Overpaid $22M; Lawyer: Feels 'More Like Enforcement'

By Nina Youngstrom

In an audit finding that gives the False Claims Act a run for the money, the HHS Office of Inspector General said that Community Hospital in Munster, Indiana, should repay Medicare $22 million based on an overpayment of $1,266,758. OIG also suggested Community Hospital "exercise reasonable diligence to identify and return any additional similar overpayments" outside the two-year audit period to comply with the Medicare 60-day refund rule.

Community Hospital billed for medically unnecessary inpatient rehabilitation facility (IRF) stays and MS-DRGs based on incorrect diagnosis codes, according to the Feb. 13 Medicare compliance review, a comprehensive audit of multiple risk areas. In response, the hospital vehemently disagreed with almost all the findings and will appeal them, calling the use of extrapolation "inappropriate" and the overpayment amount "grossly excessive."

There's a dynamic here that raises red flags for hospitals and other organizations. While the numbers rival a false claim settlement, OIG audits don't play out in the same way as an investigation. "The bigger issue is, using this audit in combination with the overpayment rule to recoup past overpayments is a powerful weapon that's different from the False Claims Act process, yet the numbers are kind of staggering," says attorney Sara Kay Wheeler, with King & Spalding in Atlanta, Georgia. There's usually more back and forth on facts and context in an investigation, which often starts with a subpoena, she says. As audit losses mount, hospitals may want to change the context of the audits because of the risk. "Interact as early as possible" with OIG, producing additional documentation to support your claims and possibly inviting auditors onsite, Wheeler says. "You are in a different posture when you're fighting Medicare compliance reviews. If you get stuck with final findings, it gets harder."