

The Medicare Program in the United States- Allegations of Inaccurate Billing at Memorial Hospital

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This paper describes some of the activities of the Health Care Financing Administration (HCFA) – the agency in the Department of Health and Human Services (HHS) responsible for administering the Medicare program – and of the Department of Justice and HHS Office of Inspector General. These three agencies act as stewards, auditors and investigators over the Medicare trust fund, where in fiscal year 2000, the U.S. spent over \$200 billion for health care services on behalf of its elderly and some disable beneficiaries. In an attempt to contain hospital costs – the most expensive part of the Medicare program – the Congress has developed payment systems that reward efficiency, and has provided funding to these overseers to assure the integrity of hospitals` billing practices. This paper also describe some of the tools used by hospitals can develop comprehensive compliance programs to prevent, detect or resolve instances of conduct within the hospital that do not conform to law.

This paper describes the case of a fictitious hospital that, like many hospitals in the U.S. today, find themselves under the scrutiny of HCFA, the Justice Department and the Inspector General. In this case, the hospital was alleged to have routinely billed Medicare incorrectly by submitting health care claims that did not coincide with the actual care provided to its patients. Examples of erroneous billing are: “upcoding,” where hospitals bill for a more complex, and therefore more costly to treat, services; “miscoding,” where the hospitals bills for a different services than was provided; and, “unbundling,” which is the practice of submitting bills piecemeal to maximize the reimbursement for various tests or procedures that are required to be billed together, and therefore at a reduced cost.

The government has several civil oversight tools at its disposal, the most powerful undoubtedly being the False Claims Act. Under this act, people who “knowingly” submit false claims may be found liable for penalties of between \$5,500 and \$11,000 for each false claim, plus up to three times the amount of the damages caused to the federal program. The cumulative effect of even small overpayments can translate to significant program losses in the Medicare program, because of the number of claims and providers involved. In fiscal year 2000, HCFA and its contractors processed over 900 million health care claims for services provided by about a million physicians, institutions and other health care providers. In addition to penalties and damages, the paper discusses the development of a corporate compliance program – a series of activities tailored to the individual hospital that establishes a culture of ethical behavior and that better assures adherence to Medicare rules.

The CEO of Memorial Hospitals in this paper has several options to resolve the allegations of erroneous billing. The paper discusses the real issues hospitals face as they decide on what action is most prudent in their particular circumstances.