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With Request for Vendor Memos, OIG Begins Audit of Outlier Payments and Device Credits

By Nina Youngstrom

In an evolution of a longstanding risk area, a national audit is underway of outlier payments for claims with manufacturer credits for replaced medical devices. Some hospitals have received or will receive a request for documentation from the HHS Office of Inspector General (OIG) of Medicare charges and "related supporting documents for medical devices that were credited from the manufacturer that impact outpatient outlier claim payments."

Plans for the audit were announced in January on OIG's Work Plan, and apparently auditors have gotten to work. OIG is looking beyond the usual issue of whether hospitals passed on manufacturer credits for replaced medical devices to Medicare, says Patrick Kennedy, compliance officer at UNC Hospitals in Chapel Hill, North Carolina, which got an OIG request for documentation, including vendor credit memos. "It's different because the outlier payments are in addition to the APC payments," he explains.

Outlier payments are bonuses that hospitals receive when costs for patient care are exceptionally high. When hospitals report manufacturer credits but forget to reduce their charges for procedures for explanted medical devices, they create a gap that could generate undeserved outlier payments, adds Stephen Gillis, director of compliance coding, billing and audit at Partners HealthCare in Boston. "It's almost like you try to do the right thing, but unless you do it completely, you could still be in hot water," he says.

CMS requires hospitals to pass on to Medicare the credits they receive from manufacturers for recalled or malfunctioning medical devices or for medical devices implanted free as part of clinical trials. CMS in 2015 changed the way that hospitals report device credits, which are used to reduce Medicare payments for inpatient and outpatient procedures performed to replace or fix devices, such as pacemakers and defibrillators. Explanted devices with a manufacturer credit of 50% or greater are reported on Medicare claim forms with value code FD (credit received from the manufacturer for a medical device) and, if applicable, condition code 53 (initial placement of a medical device provided as part of a clinical trial or free sample).

For the audit, OIG is very specific in its documentation requests. "Of particular importance, providers must have and provide the vendor's invoice and credit memo for the explanted device," Kennedy says. "This is the only way a provider, and the OIG, know if the credited amount was greater than or less than the 50% threshold. The vendor's credit memo also represents the value code amount on the provider's claim (UB) to Medicare. If the provider identifies errors in their billing to Medicare, they should correct the claim and provide the OIG with a copy of the corrected (UB) claim."

How Improper Outliers Are Generated

OIG's Work Plan previewed the audit. The Work Plan states that OIG will focus on "overstated Medicare charges on outpatient claims that contain both an outlier payment and a reported medical device credit." Previous audits have focused on unreported medical device credits.

Whether outlier payments were generated inappropriately depends on how hospitals reported their charges. Suppose the hospital pays $10,000 for a medical device that malfunctions. When it's replaced, the manufacturer gives the hospital a $6,000 credit (greater than 50%), which the hospital reports on the claim form with value code FD. "That's how Medicare knows to reduce the APC payment amount," Gillis says. Assume the original APC payment for this service would have been $15,000, but when the device credit is applied, the APC payment is reduced by $6,000 and is now $9,000. The hospital originally marked up the device to $20,000, but the new cost for the device (after the credit) is $4,000, so a markup of twice the cost would be $8,000. If the procedure plus device cost is allowed to stand, the revised claim total would be $50,000 minus $9,000 for the device credit. That's a $41,000 "delta" between charges and payments, which could cause an outlier payment, Gillis says. "If you forget to reduce the charges to reflect the lower cost for the device, the gap between charges and payment increases and can sometimes cause an outlier situation," Gillis says (see box below).

If the charges had been revised correctly after the device credit, the device charge on the claim would be $8,000, reducing total charges by $12,000. Then the difference between charges and payment would be $29,000 ($38,000 charge minus $9,000 payment), with no outlier payment generated.

One reason things go wrong is because of "token" charges that hospitals enter on claim forms. When they replace a medical device at no cost (e.g., because of a warranty or recall), hospitals shouldn't charge for it, according to CMS. But some billing systems require them to enter a charge. In that case, hospitals should submit a token charge, CMS says, such as $1.01 on the line with the device code.

"A common problem is providers who received a full credit or a device for free may put a token charge on the line item for that particular device, not the procedure," Kennedy says. CMS requires charges to line up with the procedure, but that can be counterintuitive. Also, he says, hospitals may put the wrong amount on the token charge line item, and that could generate an outlier. For example, if the device cost $20,000 and the hospital received a free replacement device, it should report $20,000 in the value code amount field and a token charge, such as $1.01, because of the 100% credit, Kennedy says. "If the hospital reported the full cost in charges, it could potentially trigger an outlier payment. $1.01 would not," he explains.

Token charges are easier said than done. "Entering a token charge is an operational obstacle because it requires manual intervention into revenue cycle processes that providers are trying to automate more and more," Kennedy says. "In most cases, automation is a good thing that helps reduce errors, but not in this situation. Moreover, it likely requires providers to wait an unknown period of time for an outside vendor to provide the information needed to determine if the token charge is applicable or if providers can charge the full amount of the device."

Credit Reporting Is a Quagmire

Gillis says token charges also apply to device-dependent APCs. CMS wants hospitals to report token charges of a penny because otherwise claims will deny. It shows hospitals are billing for device-dependent APCs, but no devices are separately reported on the claim.

Compliance with device credit reporting requirements is "complicated because you have so many hands in the pot," Kennedy says. "Not one area has the full picture." (Hospitals Hit Snags With Device Credits; Mayo Has Workflow to Improve Reporting, *RMC* 26, no. 17)

He says it starts at the point of patient care. Hospitals rely on nurses and physicians to clearly identify when and why they explanted medical devices, but they are obviously focused on taking care of the patient. Explanted medical devices are returned to vendors from clinical departments, and hospitals have to wait to hear whether there will be a credit and, if so, how much. They eventually receive credit memos from vendors reporting the

percentage of the credit, which depends partly on whether the device is under warranty. "From a billing standpoint, are you going to hold back claims until you hear from the vendor?" Or submit claims and then correct them when credit memos come in. "We are trying to hold the claims as long as we can," Kennedy says. "Our clinical areas are still involved, and we have worked toward getting purchasing more involved in chasing the vendor to get an answer on the credit quicker. These cases are usually high-dollar cases, so 30 days is our mark."

The credits should be transparent because vendors are supposed to report them to CMS and OIG, he says.

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Examples: Generating Outlier Payments When Reporting Charges and Credits for Medical Devices

Here are examples of the correct and incorrect ways of reporting charges and credits for replaced medical devices that will generate outlier payments, which is the target of a new audit by the HHS Office of Inspector General (see story, above). These examples were developed by Stephen Gillis, director of compliance coding, billing and audit at Partners HealthCare in Boston. Contact him at sjgillis@partners.org.

Assumptions:				
device cost = $10,000				
charge amount for device based on a markup of 2x = $20,000				
Original Claim				
Original Claim total charges (includes device)	$50,000			
Original claim total payment	$15,000			
Difference between charges and payments	$35,000			
Outlier triggered?	No			
Hypothetical Scenario 1				
Device credit received, greater than 50% of cost	$6,000	New cost for the device is $4,000 with 2x markup equals new charge of $8,000.		
Claim adjusted to reflect FD value code with $6,000 value code will decrease APC payment by $6,000.				
Forgot to reduce the $20,000 charge to reflect a reduction in the cost of the device so total charges remain at $50,000				
Revised claim #1 - with incorrect charges		**Revised claim #1 - with correct charges**		

Revised Claim total charges (includes device)	$50,000		Revised Claim total charges (includes device)	$38,000
Revised claim total payment (from FD = 6,000)	$9,000		Revised claim total payment (from FD = 6,000)	$9,000
Difference between charges and payments	$41,000		Difference between charges and payments	$29,000
Outlier triggered?	Yes		Outlier triggered?	No
Hypothetical Scenario 2				
Device credit received (full replacement cost)	$10,000	New cost for the device 0 and a token charge of .00 or .01 should be reported.		
Claim adjusted to reflect FD value code with $6,000 value code will decrease APC payment by $6,000.				
Forgot to reduce the $20,000 charge to reflect a reduction in the cost of the device so total charges remain at 50,000				
Revised claim scenario 2 – with incorrect charges			**Revised claim scenario 2 – with correct charges**	
Revised Claim total charges (includes device)	$50,000		Revised Claim total charges (includes device)	$30,001
Revised claim total payment (from FD = 10,000)	$5,000		Revised claim total payment (from FD = 10,000)	$5,000
Difference between charges and payments	$45,000		Difference between charges and payments	$25,001
Outlier triggered?	Yes		Outlier triggered?	No
Reporting the device credit with FD value code reduces the APC payment amount by the amount of the credit.				
If you forget to reduce the charges to reflect the lower cost for the device, the gap between charges and payment increases and can sometimes cause an outlier situation.				