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At CMS's Behest, Hospitals Self-Audit Unreported Device Credits; Deadline Is Close

By Nina Youngstrom

Some hospitals are facing a late August deadline to pay Medicare back for unreported cardiac device credits in the wake of a national HHS Office of Inspector General (OIG) audit that found significant noncompliance.[1] CMS has sent some hospitals letters instructing them to self-audit claims for procedures with replaced cardiac devices where manufacturers had given them credits and, where appropriate, return overpayments to Medicare. One caveat: before, during or after OIG's audit, hospitals may have refunded overpayments, a compliance officer said. They should check where they stand before a duplicative self-audit, although hospitals may find some unreported device credits are always lurking.

Meanwhile, hospitals should be poised for more self-audit requests after OIG audits, said Steve Gillis, director of compliance coding, billing and audit at Mass General Brigham in Boston. "This is a theme we have been seeing with CMS." It happened, for example, when Medicare administrative contractors (MACs) demanded overpayments caused by noncompliance with the post-acute care transfer (PACT) payment policy after OIG audit found noncompliance related to the PACT policy and home health care.

Deadline Looms for Device Credit Self-Audit

With the unreported device credits, CMS said it believed it would take six months for hospitals to determine whether possible overpayments stemmed from unreported cardiac device credits because of their complexity, said attorney Jeff Thrope, with Foley & Lardner LLP, who has seen a copy of a letter. When the review is completed, "the letter indicated that facilities would have 60 days to refund any overpayments and provide a detailed explanation of the methodology used in their review," he said. "If a facility believes they need more time, they can express that to CMS," the letter stated. Hospitals that use statistical sampling and extrapolation to calculate their overpayments, for example, may require an extension, he said.

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. It's a big risk area because CMS uses device credits 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).

But hospitals often drop the ball. According to the report, OIG reviewed Medicare payments to 911 hospitals for claims that had a cardiac device replacement procedure with a date of service that matched to the device replacement procedure date on the credit listing. Its findings: "For 3,233 of the 6,558 Medicare claims that we reviewed, hospitals likely did not comply with Medicare requirements associated with reporting manufacturer credits for recalled or prematurely failed cardiac medical devices." About half the claims weren't billed with the condition and value codes, OIG said. As a result, the hospitals received $76 million for the procedures involving

cardiac device implants instead of the $43 million they should have received. Presumably all of those hospitals have or will receive letters requiring them to self-audit and return identified overpayments, Thrope said.