

HEALTH CARE LAW

Expert Analysis

Enhanced Scrutiny of COVID-19 Medicare Payments and Data Reporting for Hospitals

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The federal government continues to evolve the requirements for how hospitals should deal with the COVID-19 pandemic. Last month, it finalized two significant new rules that impose regulatory hurdles for hospitals seeking desperately needed financial assistance from federal programs, including enhanced payments under the Medicare program. A hospital's failure to implement these new rules threatens eligibility for much-needed enhanced payments, or worse, government fraud actions to recoup reimbursement already received.

Scrutiny of Enhanced Payments for COVID-19 Inpatient Discharges

As part of the Coronavirus Aid, Relief, and Economic Security

(CARES) Act, hospitals paid under the Inpatient Prospective Payment System, long-term care hospitals, and inpatient rehabilitation facilities are entitled to receive a 20% increase in reimbursement for treatment of a Medicare patient diagnosed with COVID-19 who is discharged during the COVID-19 public health emergency period. These enhanced payments provide critical support to hospitals by helping offset the higher cost of treating COVID-19 patients, including the purchase of neces-

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sary supplies and equipment such as personal protective equipment (PPE) and ventilators. The CARES Act does not address documentation requirements to qualify for the 20% funding boost, and initial guidance suggested that documentation that



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an individual has COVID-19 would suffice.

Effective with admissions occurring on or after Sept. 1, 2020, however, the Centers for Medicare & Medicaid Services (CMS) imposed a new requirement that hospitals must have a positive COVID-19 lab test documented in the patient's medical record in order to receive the enhanced payment. Under the revised CMS guidance, only positive tests using the results of viral testing (i.e., molecular or antigen) consistent with Centers for Disease Control and Prevention guidelines will be accepted. Further, the underlying test may be performed by an entity other than the hospital, but in any case must be conducted within 14 days of the hospital admission. Where a hospital diagnoses a patient with COVID-19 but does not have

evidence of a positive test result, the hospital is expected to decline the enhanced payment at the time of claim submission by entering a “No Pos Test” billing note or remark on the claim.

The positive COVID-19 test requirement increases the burden on hospitals seeking much-needed relief as they grapple with the pandemic’s impact on their communities. Industry groups have pointed to the fact that accuracy rates for the most widely available types of COVID-19 tests vary widely and may produce false negatives. Hospitals have also expressed concern that the policy may require unnecessary retesting to the detriment of the already-strained U.S. testing system.

Nevertheless, hospitals should expect significant oversight activity by the government surrounding these enhanced payments for inpatient discharges. CMS has clearly put providers on notice of its intent to conduct post-payment medical reviews of COVID-19 claims to confirm the presence of a positive viral test result and recoup any identified overpayments. Contemporaneous with the release of the new guidance from CMS, the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) also added a new item to its Work Plan on this topic. Specifically, the OIG’s Office of Audit Services (OAS)

will be auditing whether Medicare payments to hospitals for COVID-19 inpatient discharges complied with CMS requirements.

OIG-OAS’s audit activities will likely lead to recommendations for CMS to initiate recoupment actions against any hospitals found to have received overpayments, and possibly referrals for further OIG action under the Civil Monetary Penalties Law based on alleged submission of false or improper claims. Additionally, providers can anticipate an uptick in opportunistic False Claims

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Act actions by whistleblowers alleging that hospitals fraudulently claimed the 20% payment enhancement when the patient’s treatment and corresponding discharge were not, in fact, based on an appropriately confirmed and documented COVID-19 diagnosis.

Medicare Participation Consequences of Failing To Report COVID-19 Data

In addition to tightening the purse strings for services provided to patients suffering from COVID-19, CMS released a controversial interim final rule (IFR) on Aug. 24, 2020,

that will require hospitals to submit specific COVID-19 data to HHS on a routine basis as a condition of participation in Medicare. The emergency rule, which became effective on Sept. 2, 2020, requires hospitals to report specific data elements, including, but not limited to, the number of confirmed or suspected COVID-19-positive patients; the number of intensive care unit beds occupied; and availability of supplies and equipment, such as PPE and ventilators.

The issuance of the IFR represents the latest and most draconian pivot in the federal government’s position on how hospitals should report COVID-19 data to facilitate planning, monitoring, and resource allocation during the public health emergency. Since late March 2020, hospitals have been encouraged to voluntarily report COVID-19-related information on a daily basis, either to the federal government directly or through existing state-based reporting mechanisms. While the majority of hospitals have made good-faith efforts to report the requested data, CMS expressed its belief that a universal reporting mandate is “necessary for CMS to monitor whether individual hospitals ... are appropriately tracking, responding to, and mitigating the spread and impact of COVID-19 on patients, the staff who care for them, and the general public.”

Importantly, the creation of a new condition of participation tied to reporting COVID-19 data in accordance with a frequency and in a standardized format specified by CMS has generated considerable confusion and questions among hospitals and health systems. For example, the data points spelled out in the IFR are not exhaustive of the items that the agency may ultimately require hospitals to submit. Nor is it clear what channels hospitals will be expected to use when submitting information or how CMS will evaluate whether hospitals have reported complete data.

Further, CMS has stated that hospitals that “fail to consistently report test results” throughout the duration of the COVID-19 public health emergency will be deemed non-compliant with the new condition of participation and subject to termination of their Medicare provider agreement. However, the details of the enforcement process—for example, how many warning letters will be issued before CMS pursues termination of a provider agreement and what mechanisms hospitals will have to challenge findings of noncompliance—remain unclear. Interestingly, CMS acknowledged in the IFR that the agency lacks the statutory authority to impose civil monetary penalties against hospitals, but has found interme-

mediate penalties to be an “extremely useful tool” in enforcing reporting requirements for nursing homes. As such, CMS expressed its intention to utilize all available enforcement and payment authorities to incentivize and promote hospitals’ compliance with the new data reporting mandate.

Risk Mitigation Steps for Hospitals and Health Systems

As discussed above, the government continues to take aggressive steps when it comes to enforcing COVID-19-related payment requirements, and is poised to use Medicare program participation as leverage to compel hospitals’ timely reporting of COVID-19 data. These new restrictions and standards place added burden and stress on hospitals that are already facing significant resource, staffing, and capital constraints on the frontlines of battling the COVID-19 pandemic. Nevertheless, it is important for hospitals to be prepared for heightened monitoring, auditing, and other inquiries from the government and its contractors.

Specifically, hospitals should ensure that their billing and coding staff are aware of the new requirements surrounding payment for COVID-19 inpatient discharges. Hospitals should have systems in place to verify that a patient’s medical record contains docu-

mentation of a positive COVID-19 test result within the prescribed time parameters before dropping a claim. It will also be important for revenue cycle staff to keep apprised of and follow any instructions from the hospital’s Medicare Administrative Contractor on the appropriate process for declining enhanced payments where evidence of a positive COVID-19 test result is missing from the medical record. Additionally, and to the extent payment has already been received, if the patient’s medical record lacks the positive COVID-19 test, hospitals should refund the 20% Medicare payment enhancement—consistent with obligations under the 60-day Overpayment Rule.

Lastly, CMS has yet to release definitive enforcement guidance for the new COVID-19 data reporting mandate, but such guidance is anticipated soon. In the meantime, hospitals should familiarize themselves with the list of COVID-19 data points referenced in the IFR, and evaluate their internal processes and systems for collecting data to ensure preparedness for making the required reports.