April 24, 2020

Update on Medicare Audits During COVID-19

When the President of the United States declares an emergency or disaster under either the Stafford Act or the National Emergencies Act, in conjunction with the Secretary of the U.S. Department of Health and Human Services’ declaration of a public health emergency, Section 1135 of the Social Security Act authorizes the Secretary to temporarily waive or modify certain Medicare, Medicaid, CHIP, and HIPAA requirements.

As a result of the 2019 novel coronavirus (COVID-19) pandemic, the Secretary declared a public health emergency on Jan. 31, 2020, and the President issued a national emergency declaration on March 13, 2020. Many 1135 waivers have been granted by the Secretary, leading to various regulatory changes. Following these regulatory changes, the Centers for Medicare & Medicaid Services (CMS) and the Office of Medicare Hearings and Appeals (OMHA) have made temporary changes to Medicare audits and the appeals process.

Much of what CMS deals with are the first few levels of Medicare appeals, but because of COVID-19 and its unique challenges, these appeals are harder to conduct in a timely matter. CMS will take the following steps for Medicare appeals involving Medicare Fee-For-Service (FFS), Medicare Advantage (MA), and Part D audits that had already been initiated prior to the pandemic:

- Providing extensions to file an appeal;
- Waiving timeliness requirements for requests for additional information to adjudicate the appeal;
- Processing the appeal even with incomplete appointment of representative forms, but communicating only to the beneficiary;
- Processing requests for appeals that do not meet the required elements, but using information that is available; and
- Utilizing all flexibilities available in the appeals process if good cause is satisfied.

Certainly, much has changed due to the ongoing COVID-19 pandemic, particularly as it applies to OMHA. OMHA administers the third level of appeal in the Medicare appeals process, and operates separately from CMS. OMHA plans to continue its hearings and appeals through telework, so current appellants should plan on continuing as scheduled, unless they specifically hear from OMHA otherwise.
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However, the OMHA Administrative Law Judges (ALJs) do have flexibility to grant reasonable requests to reschedule hearings and reasonable requests for extension of time to file a request for hearings.

Thus, while existing audit appeals remain in place, providers should expect to see fewer new audits being conducted, particularly for MA organizations, Part D sponsors, Medicare-Medicaid plans, and Program for All-Inclusive Care for the Elderly (PACE) organizations. Providers should still note, however, that CMS is still overseeing these programs, but have shifted the priority of routine overpayment audits to investigating: (1) instances of noncompliance in which the health and safety of beneficiaries are at serious risk, and (2) complaints alleging infection control concerns, including COVID-19 or other respiratory illnesses.

CMS is also suspending most FFS medical review during the COVID-19 pandemic. Specifically, CMS is suspending pre-payment medical reviews done by Medicare Administrative Contractors (MACs) under the Targeted Probe and Educate (TPE) program, and most post-payment reviews conducted by MACs, Supplemental Medical Review Contractors, and Recovery Audit Contractors.

TPE audits generally focus on providers with a history of high claim error rates, or providers that have unusual billing practices in comparison to similarly situated providers. If a provider is flagged for review, 20-40 claims and supporting medical records will be reviewed by the MAC, and if deemed not to be in substantial compliance, the provider will engage on a one-on-one education session, and be subject to another round of review. This process repeats up to three times, or until the provider is deemed to be in substantial compliance with the program. Any TPE reviews that had been initiated before the public health emergency was declared will be suspended, and claims will be released and paid. The same goes for the post-payment reviews mentioned above. However, CMS has indicated that audits may still be conducted in cases in which significant fraud and abuse is suspected. Accordingly, there is no current information specifically addressing whether Unified Program Integrity Contractors (UPICs) will or will not continue fraud investigations.

Furthermore, because many providers are using telemedicine as a resource for treating COVID-19, CMS has updated its guidelines for billing telemedicine services, and HHS will not be conducting audits to track whether there was a prior-patient physician relationship for claims submitted during the public health emergency. It is also important to note that there has been an 1135 waiver granted to
relax HIPAA requirements, especially as it pertains to providing telemedicine to patients.

Therefore, providers and suppliers that are currently undergoing an audit appeal should continue to go through the process as they normally would, but they will be granted some leniency by CMS or ALJs if an extension is needed. However, providers and suppliers should expect to see little to no new audits until the end of the public health emergency is declared.

Source RACmonitor: Original Story April 22, 2020