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Evan Schrode (eschrode@polsinelli.com) is an Associate at the Atlanta, GA, offices of Polsinelli PC.

Rebecca Hsu (rhsu@polsinelli.com) is an Associate at the Atlanta, GA, offices of Polsinelli PC.

Ross Burris (rburris@polsinelli.com) is a Shareholder at the Atlanta, GA, offices of Polsinelli PC.

The latest in government audit: Five takeaways from 2023

by Evan Schrode, Rebecca Hsu, and Ross Burris

Government contractors continue to revamp their audit activities following a relative slowdown during 2020 and 2021 at the height of the COVID-19 pandemic. 2023 brought a lot of changes for providers in the audits and reimbursement disputes realm, and these changes have established patterns that can be expected to endure beyond this year. This article focuses on five notable audit trends from 2023 of which providers should be aware to prepare for 2024 and beyond.

The end of the Medicare appeals backlog

For the better part of the past decade, the Office of Medicare Hearings and Appeals (OMHA)—which oversees administrative law judge (ALJ) hearings relating to Medicare audit and overpayment appeals—encountered significant delays over the past in administering and adjudicating ALJ hearings. These delays were so substantial that the American Hospital Association—with three other regional hospitals and healthcare systems—sued the U.S. Department of Health and Human Services (HHS) secretary in May 2014, seeking to compel HHS to comply with the statutory deadlines the Medicare Act imposes on the appeals process.[1]

In 2018, the U.S. District Court for the District of Columbia issued a mandamus order directing HHS to clear the Medicare backlog by the end of financial year (FY) 2022.[2] However, at the end of the first quarter of 2022, OMHA had 52,641 appeals remain pending, which was down from 60,062 appeals at the end of the fourth quarter of 2021. Due to the significant backlog of Medicare appeals, the average wait time for those provider appeals to be heard in 2021 was 1,259 days or almost four years.

Notwithstanding, the U.S. District Court acknowledged in an October 26, 2022, order that HHS had achieved admirable results; the court modified its original mandamus order such that HHS was required reduce the prior pending backlog by 98% by the end of the second quarter of FY 2023 and ordered the parties to submit a new status report on April 7, 2023, setting forth the backlog-reduction percentage as of March 30, 2023, and a summary of their positions on how the court should proceed with the backlog.[3]

In a Joint Status Report filed on April 7, 2023, the parties stated that as of March 31, 2023, only 663 backlogged cases were remaining, which the parties asserted surpassed the court's 98% reduction target set in its October

26, 2022, order.[4] As a result of HHS's progress, the Court terminated its original mandamus order compelling HHS to reduce the backlog and withdrew its supervision over the backlog reduction on April 10, 2023.[5]

After almost 10 years since the litigation began, HHS has essentially eliminated the backlog of Medicare appeals. Providers should continue to expect quick turnaround times between when a provider files a request for an ALJ hearing and the ALJ hearing.

OTC COVID-19 test demonstration

From April 4, 2022, until the conclusion of the COVID-19 public health emergency on May 11, 2023, the Centers for Medicare & Medicaid Services (CMS) conducted a demonstration under which Medicare provided coverage and payment for over-the-counter (OTC) COVID-19 tests at no cost to beneficiaries with Medicare Part B.[6] This demonstration also covered those enrolled in original Medicare and Medicare Advantage plans. Under the demonstration, eligible providers and entities were authorized to distribute up to eight U.S. Food and Drug Administration (FDA)-approved or authorized OTC COVID-19 tests per calendar month to each beneficiary; CMS set a fixed national payment rate of $12 per OTC COVID-19 test.[7] If, however, a provider's charge for a test was less than this rate, Medicare would pay the lower amount. Notably, beneficiaries could obtain these tests without a physician's order or supervision, simplifying access to testing. This initiative represented a shift in Medicare policy, addressing the urgent need for accessible COVID-19 testing during the pandemic.

Under the demonstration, participating providers and entities were advised to keep records demonstrating a beneficiary's request for the tests, as failure to provide documentation could lead to CMS recouping payments or taking other administrative actions.

The demonstration was successful, and CMS disbursed approximately $1.1 billion for about 101 million OTC COVID-19 tests to nearly eight million Medicare beneficiaries. However, this period also saw a rise in healthcare fraud activities. The U.S. Department of Justice (DOJ) on April 20, 2023, announced criminal charges against 18 defendants across nine U.S. federal districts for their involvement in various fraud schemes related to healthcare services during the pandemic, including the distribution of unsolicited OTC COVID-19 tests.[8] Concurrently, CMS reported taking adverse administrative actions against 28 medical providers for their alleged roles in COVID-19-related schemes.[9] In August 2023, HHS Office of Inspector General (OIG) announced a work plan to evaluate whether Medicare payments to eligible providers for OTC tests complied with the demonstration's guidelines.[10]

OIG is slated to publish its findings from the work plan in 2024, and providers should expect a noticeable increase in audits and overpayment demands associated with the provision of OTC COVID-19 test kits. Providers who participated in the demonstration should diligently maintain documentation of a patient's request for COVID-19 tests in anticipation of potential audit inquiries. This vigilant approach to recordkeeping is essential for providers to demonstrate compliance and avoid potential recoupments or other actions by CMS.