

THREE KEY THINGS IN HEALTH CARE

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In the midst of the public health emergency brought on by the COVID-19 pandemic, the Centers for Medicare & Medicaid Services (“CMS”) pressed “pause” on routine surveys of health care facilities and certain related enforcement actions. But with CMS signaling its readiness to hit “resume” providers must be prepared to respond quickly with plans of correction (“POCs”).

- In response to dangers posed by COVID-19, CMS suspended in March of this year certain federal and state surveys for long term care facilities, hospitals, home health agencies, intermediate care facilities for individuals with intellectual disabilities, and hospices, and focused efforts on infection control and immediate threats to patient health and safety. CMS also suspended certain enforcement actions against such health care facilities and permitted providers to delay the submission of POCs.
 - Despite these suspensions, CMS still found time to impose more than \$15 million in civil monetary penalties on nursing homes for noncompliance with infection control requirements and failure to report COVID-19 data.
- CMS has since released guidance, most recently on August 17, 2020, titled [“Enforcement Cases Held during the Prioritization Period and Revised Survey Prioritization”](#) (the “Survey Memorandum”), directing states to undertake a wider range of surveys, such as onsite revisit surveys, non-immediate jeopardy complaint surveys and annual recertification surveys, as soon as necessary resources, namely staff and personal protective equipment, become available. In the Survey Memorandum, CMS outlines how it will resolve enforcement actions suspended because of survey prioritization changes and describes its temporarily expanded desk review policy.
- Although CMS previously delayed the submission of POCs, they are now becoming due—and quickly. For example, CMS provides that long term care facilities with enforcement actions initiated from March 23, 2020 to May 31, 2020, will have only ten days from being contacted by a state survey agency to submit their POCs. CMS recognizes meeting the tight deadline may not always be possible and urges providers that “may have difficulty allocating resources, such as staff, materials, or funding to develop and implement a POC because they are currently experiencing an outbreak of COVID-19” to contact their state survey location or CMS contact to request an extension.
- **Key Takeaway:** Routine surveys and related enforcement actions paused due to COVID-19 are back on the proverbial front burner. Providers that had enforcement actions put on hold must now be prepared to fast track submitting POCs and any evidence that supports correction of noncompliance.

Hospitals must ensure that medical records for patients admitted for COVID-19 treatment on or after September 1, 2020 contain documentation of a positive COVID-19 laboratory test, or face recoupment.

- Recognizing the potentially significant expense of caring for hospitalized COVID-19 patients, Congress provided in the CARES Act for certain add-on payments for COVID-19 patients under the inpatient prospective payment system (“IPPS”).

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- Pursuant to Section 3710, Congress directed the Secretary of the Department of Health and Human Services (“HHS Secretary”) to increase the MS-DRG weighting factor by 20% for COVID-19 discharges, specifically requiring the HHS Secretary to identify COVID-19 discharges “through the use of diagnosis codes, condition codes, or such other means as may be necessary” and authorizing the HHS Secretary to implement Section 3710 “by program instruction or otherwise” notwithstanding any other provision of law.
- Until recently, claims eligible for the 20% add-on were identified by the following ICD-10-CM diagnosis codes:
 - B97.29 (other coronavirus as the cause of diseases classified elsewhere) for discharges on or after January 27, 2020, and on or before March 31, 2020
 - U07.1 (COVID) for discharges occurring on or after April 1, 2020, through the duration of the public health emergency period
- Citing “potential Medicare program integrity risks,” however CMS issued a revised MLN Matters SE20015 on August 17, 2020, requiring medical record documentation of a positive COVID-19 laboratory test for hospital admissions on or after September 1, 2020.
 - Testing methods are limited to molecular and antigen testing, consistent with CDC guidelines.
 - Testing may be performed during (or within 14 days of) hospital admission by the admitting hospital or by another entity. For example, CMS states a copy of a positive COVID-19 test result obtained a week before admission from a local government-run testing center could be manually included in the patient’s medical record to meet this requirement.
 - In limited instances, results from tests performed more than 14 days prior to admission may be acceptable. “In the rare circumstance where a viral test was performed more than 14 days prior to the hospital admission,” CMS states it “will consider whether there are complex medical factors in addition to that test result” for purposes of the documentation requirement.
- Hospitals will be subject to post-payment medical review to confirm the presence of a positive COVID-19 test result. If the medical record does not contain the required documentation, CMS intends to recoup the add-on payment resulting from the 20% increase to the MS-DRG relative weighting factor.
- It is unclear what prompted CMS to implement the documentation requirement. CMS FAQs dated May 27, 2020, addressing Section 3710 of the CARES Act and that are included in a larger FAQ document last updated on August 7, 2020, make no mention of a requirement for the medical record to contain documentation of a positive COVID-19 test. However, CMS is almost certainly relying on the broad authority vested in the HHS Secretary under Section 3710 to identify COVID-19 discharges by “such other means as may be necessary” to justify the new requirement.
- **Key Takeaway:** Hospitals must ensure patient medical records contain documentation of positive COVID-19 viral testing for COVID-19 admissions on or after September 1, 2020. A hospital that

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diagnoses a patient with COVID-19 consistent with ICD-10-CM guidelines but that does not have evidence of a positive test result should decline, at the time of claim submission, the additional payment resulting from the 20% add-on by notifying its Medicare Administrative Contractor (“MAC”).

Health care providers should not be dissuaded from aggressively pursuing recovery for business interruption losses related to COVID-19.

- A recent opinion piece in the Wall Street Journal raises dire predictions of insurance industry bankruptcies if claims against business interruption policies are allowed, going so far as to brand the *efforts* of lawyers advancing such claims “unconstitutional and dangerous.”¹ The piece goes on to argue whether such claims find support before the judicial branch (state court judges construing insurance policies) or legislative branch (state laws mandating coverage of COVID-related losses), the Contracts Clause of the U.S. Constitution bars state efforts to expand an insurer’s contract obligations under existing policies. The 5th Amendment’s Due Process clause is trotted out to argue against federal efforts “to impose new contracts on insurance companies.”²
- The commendable constitutional law expertise of these writers notwithstanding, their legal analysis reflects deficient understanding of the language and structure of many insurance policies, which either provide for coverage of COVID-related losses by their express terms or expressly contemplate state-mandated coverage expansions favoring the insured as binding on the insurer.
- The COVID-related losses born by many providers are or will be substantial and, in some cases, may imperil the continued viability of essential institutional providers in the health care delivery system—the dimension of these losses underscores precisely the reason why businesses, including hospitals, dutifully pay premiums year after year for coverage against risks that may seem incredibly remote but potentially catastrophic. Put in lay terms, none of us buys insurance to cover routine oil changes or tire replacements—we buy insurance to cover financial exposures well beyond the thickness of our wallets.
- COVID-19 hit the hospital industry with unprecedented financial losses, essentially contaminating the community hospital as a place of business and forcing the cancellation or postponement of revenue-producing elective cases in unprecedented fashion. Constitutional saber-rattling aside, providers remain well-advised to consult with experienced insurance recovery counsel to evaluate their existing coverage arrangements and to preserve their rights to advance claims for losses that may be entirely within the scope of paid-for policies or coverage obligations as expanded under state law.
- **Key Takeaway:** The hospital sector is well-acquainted with battling claim denials for services rendered to third party insureds predicated on supposed coverage limitations; the same level of diligent pursuit of coverage under their own insurance policies is called for now.

¹ David B. Rivkin, Jr. and J. Michael Luttig, Coronavirus, Contracts and the Constitution, WSJ, August 17, 2020.

² *Id.*

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