

OIG to Audit Medicare Telehealth Services: What You Need to Know



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Published on www.lorman.com - February 2018

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OIG to Audit Medicare Telehealth Services: What You Need to Know

Posted by Nathaniel M. Lacktman – 7/31/17

For what may be the first time, the Office of Inspector General (OIG) at the Department of Health & Human Services (HHS) recently announced a new project to review Medicare payments for telehealth services. Accordingly, providers who bill the Medicare program for telehealth services may expect to have those claims reviewed to confirm the patient was at an eligible originating site and that the statutory conditions for coverage were met. The audit is a new project added as a supplement to the OIG's 2017 Work Plan.

OIG Work Plan

Historically, at the beginning of each new fiscal year, the OIG issued its Work Plan, setting forth the compliance and enforcement projects and priorities OIG intends to pursue in the coming year. Beginning in June 2017, OIG will update the annual Work Plan on a monthly basis. The Work Plan contains dozens of projects affecting Medicare and Medicaid providers, suppliers and payors, as well as public health reviews and Department-specific reviews.

The Work Plan reflects (in large part) two aspects of the work of OIG:

- 1) Projects originating within the Office of Audit Services (OAS), which conducts financial, billing, and performance audits of HHS programs; and
- 2) Projects originating within the Office of Evaluations and Inspections (OEI), which provides management reviews and evaluations of HHS program operations.

Except by providing general statistics, the Work Plan itself does not detail the work of the Office of Investigations or the Office of Counsel to the Inspector General in investigating and enforcing matters involving specific individual providers and suppliers. The new telehealth project will be run by the OAS.

Review of Medicare Payments for Telehealth Services

OIG describes its new telehealth review project as follows:

“Medicare Part B covers expenses for telehealth services on the telehealth list when those services are delivered via an interactive telecommunications system, provided certain conditions are met (42 CFR § 410.78(b)). To support rural access to care, Medicare pays for telehealth services provided through live, interactive videoconferencing between a beneficiary located at a rural originating site and a practitioner located at a distant site. An eligible originating site must be the practitioner’s office or a specified medical facility, not a beneficiary’s home or office. We will review Medicare claims paid for telehealth services provided at distant sites that do not have corresponding claims from originating sites to determine whether those services met Medicare requirements.”

The expected issue date of the OIG report is 2017, so presumably the review will commence shortly (although OIG Work Plan projects are sometimes continued or extended from year-to-year).

Medicare 2014 Telehealth Claims Data

The new OIG project is not the first time Medicare claims data has identified a potential mismatch regarding the conditions for coverage for telehealth services. A July 2016, Medicare Payment Advisory Commission (MEDPAC) Report to Congress: Medicare and the Health Care Delivery System contained a detailed chapter on telehealth

services and the Medicare program. In it, MEDPAC analyzed Medicare claims data from 2014 for preliminary qualitative assessments on the state of telehealth services under Medicare. The report included a paragraph on telehealth distant site claims without a corresponding originating site claim, stating:

“Among the 175,000 telehealth claims from distant sites, 95,000 (55 percent) were without an originating site claim. This discrepancy could be due to providers not bothering to bill for the \$25 facility fee, or it could be that some services inappropriately originated from a patient’s home, as other research has suggested (Gilman and Stensland 2013). Among the distant site telehealth claims without an originating site claim, 56 percent (53,000 visits) were associated with rural beneficiaries and 44 percent (41,000 visits) were associated with urban beneficiaries. Both claims groups suggest that beneficiaries could be inappropriately receiving telehealth services from home or another unapproved location that did not file an originating site claim. The urban claims are also potentially problematic because they could be occurring in urban originating sites, which is inconsistent with Medicare statute.”

Medicare Coverage of Telehealth Services

Current coverage of telehealth services under Medicare is limited, with the coverage restrictions established via statute under the Social Security Act. Any notable expansion of telehealth coverage under Medicare would require legislation by Congress. There are several bills pending in Congress to remove these limitations, but until such time, there are five main conditions for coverage for telehealth services under Medicare.

1. The beneficiary is located in a qualifying rural area (providers can check if the originating site is in a qualifying rural area by using the Medicare Telehealth Payment Eligibility Analyzer);
2. The beneficiary is located at one of eight qualifying originating sites (i.e., the offices of physicians or practitioners; Hospitals; Critical Access Hospitals; Rural Health Clinics; Federally Qualified Health Centers; Hospital-based or CAH-based Renal Dialysis Centers (including satellites); Skilled Nursing Facilities; and Community Mental Health Centers);
3. The services are provided by one of ten distant site practitioners eligible to furnish and receive Medicare payment for telehealth services (i.e., physicians; nurse practitioners;TM physician assistants;TM nurse-midwives;TM clinical nurse specialists;TM certified registered nurse anesthetists; clinical psychologists; clinical social workers; registered dietitians; and nutrition professionals);
4. The beneficiary and distant site practitioner communicate via an interactive audio and video telecommunications system that permits real-time communication between them (store and forward is covered in Alaska and Hawaii under demonstration programs); and
5. The CPT/HCPCS (Current Procedural Terminology/Healthcare Common Procedure Coding System) code for the service itself is named on the CY 2017 (or current year) list of covered Medicare telehealth services.

In order to bill Medicare for telehealth services, the distant site practitioner must fully comply with each of these requirements. If the service does not meet each of these above requirements, the Medicare program will not pay for the service. If, however, the conditions of

coverage are met, the use of an interactive telecommunications system substitutes for an in-person encounter (*i.e.*, it satisfies the “face-to-face” element of a service).

Providers ought not fear the new OIG project, or see it as a reason not to offer telehealth services to their patients. Indeed, the project and its eventual report can help shed light on those areas of compliance which the OIG believes important. In the interim, providers should continue to ensure their telehealth programs and claims comply with Medicare requirements, including coverage, coding, and documentation rules.

For more information on telemedicine, telehealth, and virtual care innovations, including the team, publications, and other materials, visit [Foley’s Telemedicine Practice](#).

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