



OIG Report: CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements

Prepared by:
Nathaniel M. Lacktman, Esq.
Chair, Telemedicine Industry Team
Foley & Lardner LLP
NLacktman@foley.com
www.foley.com/nlacktman

LORMAN[®]

Published on www.lorman.com - September 2018

OIG Report: CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements, ©2018 Lorman Education Services. All Rights Reserved.

INTRODUCING

Lorman's New Approach to Continuing Education

ALL-ACCESS PASS

The All-Access Pass grants you **UNLIMITED** access to Lorman's ever-growing library of training resources:

- ✓ **Unlimited Live Webinars** - 120 live webinars added every month
- ✓ **Unlimited OnDemand and MP3 Downloads** - Over 1,500 courses available
- ✓ **Videos** - More than 1300 available
- ✓ **Slide Decks** - More than 2300 available
- ✓ **White Papers**
- ✓ **Reports**
- ✓ **Articles**
- ✓ **... and much more!**

Join the thousands of other pass-holders that have already trusted us for their professional development by choosing the All-Access Pass.



Get Your All-Access Pass Today!

SAVE 20%

Learn more: www.lorman.com/pass/?s=special20

Use Discount Code Q7014393 and Priority Code 18536 to receive the 20% AAP discount.

*Discount cannot be combined with any other discounts.

OIG Report: CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements

POSTED BY NATHANIEL M. LACKTMAN ON 16 APRIL 2018

The Office of Inspector General (OIG) at the Department of Health & Human Services (HHS) just published a new report on OIG's review of Medicare payments for telehealth services. The objective of the OIG review was to determine whether or not CMS paid practitioners for telehealth services that met Medicare requirements. The report concluded that, of the sampled claims reviewed by OIG, 31% did not meet the Medicare conditions for payment for telehealth services. Extrapolating the data, OIG estimated that Medicare could have saved approximately \$3.7 million during its audit period if practitioners had provided telehealth services in accordance with Medicare requirements.

Following the report's findings, hospitals and health care providers who bill the Medicare program for telehealth services may expect to have their claims reviewed to confirm the patient was at an eligible originating site and that the statutory conditions for coverage were met. Providers should continue to ensure their telehealth programs and claims comply with Medicare requirements, including coverage, coding, and documentation rules.

For deeper discussions of Medicare coverage rules for telehealth services, as well as other telemedicine legal and reimbursement issues, please join us for "Know the Rules: Telemedicine Law and Contracting", a half-day educational program offered at the American Telemedicine Association's 2018 Annual Conference and Expo in Chicago on April 29, 2018.

OIG Medicare Telehealth Project

As we discussed last summer, the OIG Medicare telehealth review project was initially announced in July 2017 as a supplement to the OIG's 2017 work plan. The OIG project was described 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."

OIG conducted its review following a July 2016, Medicare Payment Advisory Commission (MEDPAC) Report titled "Medicare and the Health Care Delivery System" that contained a detailed chapter on telehealth services and the Medicare program. The MEDPAC report included a study that Medicare professional fee claims without associated claims for originating site facility fees were more likely to be associated with unallowable telehealth payments. OIG then analyzed telehealth claims from 2014 and 2015 (its audit period) and found that more than half of the professional telehealth claims paid by Medicare did not have matching originating site facility fee claims. Therefore, OIG focused its review on telehealth claims billed through a distant site that did not have a corresponding originating-site fee.

OIG Report Found Improper Payments for Telehealth Services

In connection with the project, OIG reviewed 191,118 Medicare paid distant-site telehealth claims, totaling \$13.8 million, that did not have corresponding originating-site claims. OIG then reviewed provider supporting documentation for a stratified random sample of 100 claims to determine whether the services were allowable in accordance with Medicare requirements for telehealth services. OIG found that CMS paid practitioners for some telehealth claims associated with services that did not meet Medicare requirements.

For 69 of the 100 claims in the sample, OIG found the services met the requirements for telehealth coverage under Medicare. However, for

the remaining 31 claims, OIG found the services did not meet Medicare requirements. Specifically:

- **24 claims** were unallowable because the beneficiaries received services at non-rural originating sites (In one example, a patient's originating site was a physician's office in Lynchburg, Virginia, which is within an MSA);
- **7 claims** were billed by ineligible institutional providers;
- **3 claims** were for services provided to beneficiaries at unauthorized originating sites (Two beneficiaries were at their residences when the services were provided, and the other beneficiary received the service at an independent renal dialysis facility);
- **2 claims** were for services provided by an unallowable means of communication (one was asynchronous and the other was telephone);
- **1 claim** was for a noncovered service; and
- **1 claim** was for services provided by a physician located outside the United States (A physician residing and practicing psychiatry in Pakistan provided psychiatric counseling services through telehealth technology to a patient located at a rural medical center in the United States. The service was unallowable because the physician was located outside the United States.).

According to OIG, the deficiencies occurred "because CMS did not ensure that (1) there was oversight to disallow payments for errors where telehealth claim edits could not be implemented, (2) all contractor claim edits were in place, and (3) practitioners were aware of Medicare telehealth requirements."

The OIG report recommended that CMS implement three things to address the issue:

1. Conduct periodic post-payment reviews to disallow payments for errors for which telehealth claim edits cannot be implemented;
2. Work with Medicare contractors to implement all telehealth claim edits listed in the Medicare Claims Processing Manual; and

3. Offer education and training sessions to practitioners on Medicare telehealth requirements and related resources.

CMS concurred with OIG's recommendations.

Medicare Coverage of Telehealth Services

Before billing Medicare for telehealth services, it is essential the hospital or healthcare provider understand and adhere to the specific conditions of coverage required by CMS. 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. The recently-signed Bipartisan Budget Act will remove some of these limitations in 2019, 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; physician assistants; nurse-midwives; clinical nurse specialists; 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).

We will continue to monitor for further updates. Note, OIG is still working on its Medicaid telemedicine project to review billing compliance for telehealth and telemedicine service claims submitted to state Medicaid programs. That report is expected to be published in 2019.

For more information on telemedicine, telehealth, virtual care, and other health innovations, including the team, publications, and other materials, visit Foley’s Telemedicine and Digital Health Industry Team and read our 2017 Telemedicine and Digital Health Executive Survey

The material appearing in this website is for informational purposes only and is not legal advice. Transmission of this information is not intended to create, and receipt does not constitute, an attorney-client relationship. The information provided herein is intended only as general information which may or may not reflect the most current developments. Although these materials may be prepared by professionals, they should not be used as a substitute for professional services. If legal or other professional advice is required, the services of a professional should be sought.

The opinions or viewpoints expressed herein do not necessarily reflect those of Lorman Education Services. All materials and content were prepared by persons and/or entities other than Lorman Education Services, and said other persons and/or entities are solely responsible for their content.

Any links to other websites are not intended to be referrals or endorsements of these sites. The links provided are maintained by the respective organizations, and they are solely responsible for the content of their own sites.