PUBLICATION

Deciphering the OIG's Findings in its Recent Report on Non-Compliant Telehealth Claims

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Last summer, we alerted our clients to the OIG's inclusion of telehealth claims to its work plan (see here and here), and we now see the results of the OIG's focused review in a report first released at the beginning of April.

The Rationale Behind the Report

As stated in the report, the reason for the OIG's concern is the increase in telehealth claims over the last 15 years from $61,302 to approximately $17 million. This suggests the OIG's expected explanation for such increases is fraudulent billing, not the fact that over the course of a decade and a half, technical innovation has exploded and consumer demand for quick and convenient health grew at a constant clip. In addition, during this time, providers were legislatively mandated to strive for the "triple aim" of increased quality, lower costs and increased patient satisfaction, all of which can be achieved with telehealth, according to industry members. Despite these factors, the OIG cited the dramatic increase in telehealth spending as grounds for its audit.

The audit began with the universe of telehealth claims billed in 2014 and 2015 for which there was a distant site claim, but no corresponding originating site claim. From that population, the OIG sampled 100 claims and found errors in various categories. Before diving into those errors, it is important to note that it is not uncommon for originating site providers to not submit originating site claims even if the distant site claim was perfectly compliant with Medicare rules. Over the last several years, we have had discussions with industry members who maintain that originating sites often do not feel the $25 (or less) fee is worth the billing effort. Added to that is the somewhat novel nature of telehealth billing and the fear of getting it wrong. In their minds, this approach reduces a compliance risk, but as this OIG report tells us, it actually puts the originating site in the OIG's crosshairs.

What the OIG Found

1. Twenty-four (24) claims were unallowable because the beneficiaries received services at originating sites that did not meet the geographic location requirement.

Medicare requires that the patient be located in an allowable "Originating Site" that is located in a rural or health professional shortage area. Specifically, the site must be in a county outside of a metropolitan statistical area (MSA) or located in a health professional shortage area (HPSA) that is either outside of an MSA or within a rural census tract. In the alternative, the Originating Site can be an entity participating in a federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000, such as Hawaii and Alaska.

These designations are subject to change based upon increasing (or decreasing) populations of residents and of health professionals. Because the report does not provide the locations of these sites, we cannot determine whether these sites' geographic locations ever met the MSA and HPSA requirements. Had they met such requirements at a prior time, it is possible some provider error was due to the provider being unaware of the location's change in status.

2. Seven (7) claims were billed by ineligible institutional providers.

As noted above, the population of claims constituted those without an originating site, so the only claim reviewed was the claim submitted by the distant site. Therefore, the reference to "institutional providers" refers to the distant site provider submitting the claim. Eligible distant site providers are limited to physicians, nurse practitioners, nurse-midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologist (CPs), clinical social workers (subject to certain limitations), and registered dieticians. The only two institutional providers eligible to bill as distant site providers are Critical Access Hospitals and facilities rendering medical nutrition therapy (MNT) services.

The OIG's report suggests that the seven claims did not reflect one of these two allowable institutions and are therefore not allowable, but does not give further detail. The report does not state whether the institutions billed the claims in their own right or via reassignment. Such a distinction is crucial in understanding the OIG's current interpretation of the Medicare telehealth coverage rules and how they apply to reassigned claims billed under Part B – a practice presumed permitted for telehealth claims as it is for other Part B claims. Baker Donelson and other telehealth attorneys are seeking additional clarity on this issue.

3. Three (3) claims were for services provided to beneficiaries at unauthorized originating sites.

In order to receive coverage and payment under Medicare, the recipient beneficiary must be located not just in the right geographic area, but also in the correct type of institution. Allowed institutions must appear on a finite list of facility types as listed below:

- The offices of physicians or practitioners
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)

Of the three claims reviewed, two claims reflected the beneficiaries' homes as the Originating Sites and one claim reflected a freestanding dialysis facility. Interestingly, both of these sites have been proposed as new additional Originating Sites in various pieces of federal legislation, including the Chronic Care Act. More recently, the new innovative Comprehensive ESRD Care (CEC) Model for telehealth services includes a waiver of the originating site requirement for services provided via telehealth. This waiver, which is described as a "benefit enhancement," will allow beneficiaries to receive qualified telehealth services in non-rural locations and locations that are not specified by statute, such as *homes* and *dialysis facilities.* This development creates an obvious disconnect between CMS's recognition of this "benefit enhancement" and the OIG's disproval of providers claims for the same service.

4. Two (2) claims were for services provided by an unallowable means of communication

Medicare requires that telehealth services be provided via technology using synchronous communication (i.e., real time communication via an audio and visual connection occurring simultaneously). Other types of technologies used for telehealth include asynchronous or store and forward technology and remote patient monitoring. Within the sample reviewed, one claim was for services rendered through asynchronous store and forward telecommunications systems, and one claim was for services rendered using the phone.

What we do not know here is what types of technologies were permitted by the applicable states in which the services were rendered. Providers have to deal with *at least* two sets of regulations and laws when providing

services via telehealth. The first is, of course, Medicare's rules and the subject of this report. The next regulatory framework is state-specific, and many state boards do include the use of asynchronous technology in their scope of telehealth practice. To the extent the two claims at issue were rendered in states with such a policy, provider error could be attributed to lack of clarity on the interplay between the Medicare and state rules and that Medicare will trump regardless of what the state allows. Few state boards consider a telephone call to constitute a telehealth service, but without knowing the applicable states, we cannot know for certain.

5. One (1) claim was for a noncovered service.

Even if the stars align and you have satisfied the above *four* elements for Medicare reimbursement, there is a fifth element, which requires that the service rendered be on CMS's list of covered telehealth services. Each year, CMS considers including additional codes based upon one of two reasons. One, CMS will include additional CPT codes as "Category One" if the services are similar to services currently on the list of telehealth services. Two, CMS will add additional CPT codes into "Category Two" based on CMS's assessment that (a) the service is accurately described by the corresponding code when delivered via telehealth, and (b) the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient as supported by submitted evidence.

The OIG found one claim in its sample billed in 2015 for crisis psychotherapy services which was not a covered service … at that time. However, effective January 1, 2018, two crisis psychotherapy codes (90839 and 90840) are Covered Services based upon Category One. Seeing as CMS itself acknowledges the similarity between these services and services already covered, it is quite possible that providers may not have been fully appreciative of the distinction and viewed it as a covered service. However, without knowing the CPT codes specifically billed in this scenario, we cannot further assess whether this was a potential for error.

6. One (1) claim was for services provided by a physician located outside the United States.

One service billed as rendered by a physician located in Pakistan. Because Medicare only covers services provided in the United States, this claim was denied.

What These Findings Mean and What We Should Expect

It is my opinion that, to the extent the OIG is suspect of the billing practices from a fraud or falsity perspective, these findings do not suggest fraudulent practices, but rather they highlight the difficulty of remaining compliant under the multiple layers Medicare telehealth coverage rules. The OIG itself acknowledged that a lack of education and training was a key contributing factor to the errors identified, and that payment of the erroneous claims was partially due to a lack of processing edits on the part of Medicare Contractors. I find it even more interesting that some of the "nonallowable" claims in 2014 and 2015 would be allowable today. Telehealth is developing and changing at warp speed, and its benefits are being recognized at a faster pace than Medicare's rules can meet, creating a compliance nightmare for providers.

Based on what we know about OIG's work plan and audit activity, we expect that telehealth claim compliance will continue to be on the OIG's radar and additional audits may be forthcoming in the future. In fact, we can expect an audit of Medicaid telehealth claims as such review was included in the OIG's work plan as well.

Providers should work with their leadership and legal counsel to ensure that they, as well as their billing entities, are educated and trained on all applicable coverage and billing rules pertaining to Medicare and Medicaid claims. CMS currently has some guidance available on its website and could add further resources as a result of the OIG report. Providers should check this resource on a regular basis. Baker Donelson will also continue to provide updates on developments in Medicare telehealth policy.