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OIG Turns Its Attention to Telehealth Medicaid Compliance

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Telehealth providers participating in and receiving payment from Medicaid for telehealth services should take heed of the newly initiated items included in the OIG's November 2017 Work Plan update. (Beginning June 2017, the OIG changed from an annual to a monthly process for issuing its Work Plan by instituting monthly updates). In particular, in the new active Work Plan item titled, "Medicaid Services Delivered Using Telecommunication Systems," the OIG notes the "significant increase in [Medicaid] claims" for telehealth, telemedicine and telemonitoring services and indicates that the OIG expects the trend to continue.

Presumably the increase in Medicaid claims and payment has triggered the OIG's focus in this area. While the OIG may suspect inappropriate billing is behind the increase, many would assert that the increased Medicaid payments is simply a result of the growth in the industry. In recent years, technological advancements have enabled providers to more readily offer this service from a logistics and cost-effectiveness perspective. Their willingness to do so is compounded by the fact that more and more patients and consumers are seeking convenient and easily accessible health care, both of which telehealth can offer.

Regardless of whether the OIG's suspicion is unfounded, however, providers must prepare. In reviewing their Medicaid program compliance, providers must consider the potential obstacle that each program's rules are different and go "program by program" to ensure they are complying with the applicable requirements. Key areas to audit include:

- Were the originating sites billed with the appropriate originating facility site codes?
- Did distant sites use the appropriate modifiers and POS codes?
- Were the appropriate codes billed? While often similar, each state's program's list of covered CPT codes is not identical.
- Was the patient at an appropriate originating site? Most state Medicaid programs have a limited list of qualified originating sites.
- Was the rendering provider an eligible distant site provider? Most state Medicaid programs have a limited list of eligible distant sites.
- Were the applicable geographic location requirements met? Though few, some Medicaid programs still limit coverage and reimbursement to the nature of the patient's location.
- Did the provider satisfy any applicable programmatic requirement? For example, some Medicaid programs require providers to "register" as a telehealth provider before billing.
- Did the technology meet the audio and visual requirements (e.g., real time audio and visual)?
- Were non-covered services billed? For example, many Medicaid programs do not cover store and forward or remote patient monitoring ("telemonitoring").
- Was the appropriate Medicaid program billed? The state in which the patient is located governs, not the distant site provider.

Compliance with the Medicaid rules applicable to telehealth is not always easy. Not only do they differ from state to state but the rules are not always easy to *find.* Most telehealth rules and requirements are found not in regulations but rather in policy manuals and transmittals, which are not always available to the public in the absence of a request to the agency.

This would be a good time for providers to conduct a due-diligence review of their telehealth service model in each and every Medicaid program in which they participate.

If you have any questions regarding telehealth, please reach out to any member of the Baker Ober Health Law Group.