

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CMS PAID PRACTITIONERS FOR
TELEHEALTH SERVICES THAT
DID NOT MEET MEDICARE
REQUIREMENTS**

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Office of Inspector General

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Report in Brief

Date: April 2018

Report No. A-05-16-00058

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Medicare paid a total of \$17.6 million in telehealth payments in 2015, compared with \$61,302 in 2001. Medicare telehealth payments include a professional fee, paid to the practitioner performing the service at a distant site, and an originating-site fee, paid to the facility where the beneficiary receives the service. A Medicare Payment Advisory Commission study of 2009 claims found that Medicare professional fee claims without associated claims for originating-site facility fees were more likely to be associated with unallowable telehealth payments. We analyzed 2014 and 2015 (our audit period) telehealth claims and found that more than half of the professional telehealth claims paid by Medicare did not have matching originating-site facility fee claims. Therefore, we focused our review on telehealth claims billed through a distant site that did not have a corresponding originating-site fee.

Our objective was to determine whether the Centers for Medicare & Medicaid Services (CMS) paid practitioners for telehealth services that met Medicare requirements.

How OIG Did This Review

We reviewed 191,118 Medicare paid distant-site telehealth claims, totaling \$13.8 million, that did not have corresponding originating-site claims. We reviewed provider supporting documentation for a stratified random sample of 100 claims to determine whether services were allowable in accordance with Medicare requirements.

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

What OIG Found

CMS paid practitioners for some telehealth claims associated with services that did not meet Medicare requirements. For 69 of the 100 claims in our sample, telehealth services met requirements. However, for the remaining 31 claims, services did not meet requirements. Specifically:

- 24 claims were unallowable because the beneficiaries received services at nonrural originating sites,
- 7 claims were billed by ineligible institutional providers,
- 3 claims were for services provided to beneficiaries at unauthorized originating sites,
- 2 claims were for services provided by an unallowable means of communication,
- 1 claim was for a noncovered service, and
- 1 claim was for services provided by a physician located outside the United States.

We estimated that Medicare could have saved approximately \$3.7 million during our audit period if practitioners had provided telehealth services in accordance with Medicare requirements.

The deficiencies that we identified 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.

What OIG Recommends and CMS Comments

We recommend that CMS (1) conduct periodic postpayment 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 our recommendations.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Review	1
Objective	1
Background	1
Administration of the Medicare Program	1
Telehealth Services.....	1
Telehealth: Conditions of Payment.....	2
Originating-Site Eligibility Requirements.....	2
Distant-Site Claims	3
Online Practitioner Resources.....	4
Contractor Claim Processing Edits.....	4
How We Conducted This Review	5
FINDINGS.....	5
Beneficiaries Received Services at Nonrural Originating Sites.....	6
Some Institutional Providers Were Ineligible To Bill for Telehealth Services.....	6
Beneficiaries Received Services at Unauthorized Originating Sites.....	7
Practitioners Used an Unallowable Means of Communication	7
A Practitioner Provided a Noncovered Service.....	7
A Practitioner Was Located Outside the United States	8
Causes of Unallowable Telehealth Claims.....	8
Medicare Contractors Could Not Implement Edits for Some Errors.....	8
Contractor Claim Processing Edits Were Not Implemented	8
Several Practitioners Were Not Aware of Requirements.....	8
RECOMMENDATIONS.....	9
CMS COMMENTS	9
APPENDICES	
A: Audit Scope and Methodology	10
B: Statistical Sampling Methodology	13

C: Sample Results and Estimates.....	15
D: Federal Requirements.....	16
E: CMS Comments.....	19

INTRODUCTION

WHY WE DID THIS REVIEW

Medicare telehealth spending increased from \$61,302 in 2001 to \$17,601,996 in 2015. Medicare telehealth payments include a professional fee, paid to the practitioner performing the telehealth service at a distant site, and an associated originating-site facility fee, paid to the facility where the beneficiary receives the telehealth service. A Medicare Payment Advisory Commission (MedPAC) study¹ of 2009 Medicare claims found that professional fee claims for telehealth services without associated claims for originating-site facility fees were more likely to be associated with telehealth services that did not meet Medicare requirements. We analyzed 2014 and 2015 (our audit period) telehealth claims and found that more than half of the professional fee claims for telehealth services paid by Medicare did not have matching originating-site facility fee claims. Therefore, we focused our review on telehealth claims billed through a distant site that did not have corresponding originating-site fees.

OBJECTIVE

Our objective was to determine whether the Centers for Medicare & Medicaid Services (CMS) paid practitioners for telehealth services that met Medicare requirements.

BACKGROUND

Administration of the Medicare Program

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the program.

Telehealth Services

Medicare telehealth services are Part B services that a practitioner provides to an eligible beneficiary through a telecommunications system. To support rural access to care, Medicare covers telehealth services provided through live, interactive videoconferencing between a beneficiary located at a certified rural originating site and a practitioner located at a distant site. An eligible originating site must be an authorized medical facility, not a beneficiary's home or office. CMS publishes an annual *Telehealth Services Medicare Learning Network* fact sheet² that provides telehealth guidance for practitioners at distant sites. Distant-site practitioners of telehealth services must be licensed to provide the services under State law. Practitioners who

¹ MedPAC. "Telehealth and Medicare: Payment Policy, Current Use and Prospects for Growth." Available online at https://www.cms.gov/mmrr/Downloads/MMRR2013_003_04_a04.pdf. Accessed on June 20, 2017.

² According to CMS, the fact sheet is intended to be only a general summary, and it is not intended to take the place of statutes and regulations.

may furnish and receive payment for covered telehealth services include, for example, physicians, nurse practitioners, and physician assistants.

Telehealth: Conditions of Payment

Effective January 1, 2015, a list of the services covered as telehealth services was available on the CMS website. Prior to January 1, 2015, the *Medicare Claims Processing Manual* (Manual)³ listed descriptions and Health Care Procedure Coding System (HCPCS)⁴ codes of allowable Part B telehealth services. Medicare generally pays for telehealth services only when an interactive audio and video telecommunications system is used, permitting real-time communication between the beneficiary at the originating site and the practitioner at the distant site. Under certain circumstances, Medicare will pay for telehealth services when furnished through an asynchronous “store and forward” system. Unlike an interactive audio and video telecommunications system, asynchronous store and forward technology is the non-interactive transmission of medical information, such as x-rays, photos, and video clips, which is reviewed at a later time by a practitioner at the distant site. Medicare will pay for telehealth services using asynchronous store and forward technology only when the originating site is part of a Federal telemedicine demonstration project⁵ in Alaska or Hawaii (42 CFR § 410.78(d)).

Originating-Site Eligibility Requirements

An originating site is the location of an eligible Medicare beneficiary at the time a service furnished via a telecommunications system occurs. Eligible originating sites must be:

- in a county outside of a metropolitan statistical area (MSA),⁶

³ The Manual, Pub. No. 100-4, chapter 12, § 190.3.

⁴ The HCPCS is a collection of standardized codes that represent medical procedures, supplies, products, and services. The codes are used to facilitate the processing of health insurance claims by Medicare and other insurers.

⁵ Federal telemedicine demonstration projects test and measure the effect of potential changes in program coverage and use of telemedicine technologies.

⁶ As defined by the Office of Management and Budget, an MSA is a Core Based Statistical Area (CBSA) associated with at least one urbanized area of at least 50,000 people. An MSA comprises the central county or counties containing the core, plus adjacent outlying counties that have a high degree of social and economic integration with the core, as measured by commuting (75 Fed. Reg. 37246, 37252 (June 28, 2010)).

- in a health professional shortage area (HPSA)⁷ that is either outside of an MSA or within a rural census tract,⁸ or
- 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.

In addition, the originating site must be one of the following: practitioner office, hospital, critical access hospital (CAH), rural health clinic, federally qualified health center, hospital-based or CAH-based renal dialysis center, skilled nursing facility, or community mental health center. Eligible originating sites may bill for the originating-site facility fee using HCPCS code Q3014, which is a separately billable Part B payment included in the Medicare physician fee schedule. This fee was approximately \$25 during our audit period.

Distant-Site Claims

Before 2018, practitioners submitted claims for telehealth services performed at distant sites by adding either a GT or GQ code modifier⁹ to the appropriate HCPCS code. Practitioners added the GT modifier to a covered telehealth HCPCS code to certify that the beneficiary was present at an eligible originating site and the telehealth services were provided via an interactive audio and video telecommunications system.¹⁰ Practitioners participating in a demonstration project use the GQ modifier to certify that the asynchronous medical file was collected and transmitted from a Federal telemedicine demonstration project in Alaska or Hawaii.

In most cases, practitioners bill Medicare for professional distant-site services. There are two situations in which an institutional facility may bill for distant-site services: (1) the facility is a CAH that elected the Method II payment option,¹¹ and the practitioner reassigned his or her benefits to the CAH, or (2) the facility provided medical nutrition therapy (MNT) services.

⁷ HPSAs are areas designated by the Health Resources and Services Administration as having shortages of primary medical care, dental, or mental health providers.

⁸ Rural census tracts are census tracts that are determined to be rural by the Federal Office of Rural Health Policy.

⁹ Code modifiers are two-digit codes that may consist of alphanumeric characters appended to HCPCS codes to provide additional information needed to process a claim.

¹⁰ Effective January 1, 2018, which was after our audit period, use of the GT modifier on professional claims for telehealth services was eliminated. The Manual (chapter 12, § 190.6.1) as amended by Transmittal 3929, Change Request 10152, dated November 29, 2017.

¹¹ The Method II payment option for outpatient professional services allows the CAH to be paid 115 percent of what would otherwise be paid under the Medicare physician fee schedule.

Online Practitioner Resources

CMS publishes the *Telehealth Services* factsheet on its Medicare Learning Network website¹² annually to address current Medicare telehealth requirements. The factsheet is a useful practitioner resource that summarizes key telehealth requirements in the Manual. The factsheet also lists allowable telehealth HCPCS codes. CMS's Telehealth website also provides a list of covered telehealth services.¹³

The Health Resources and Services Administration maintains a website tool called the Medicare Telehealth Payment Eligibility Analyzer.¹⁴ This tool allows practitioners to enter a specific address to verify whether the beneficiary is at an originating site geographically eligible for telehealth payment. The tool ensures that the address does not fall in an MSA or, if it does fall in an MSA, the address is in an HPSA within a rural census tract.

Contractor Claim Processing Edits

CMS contracts with private health care insurers known as Medicare Administrative Contractors (MACs) to process and pay Medicare fee-for-service claims, including telehealth claims. The Manual (chapter 12, § 190.7) requires the MACs to:

- install edits to ensure that only properly licensed practitioners are paid for covered telehealth services;
- deny services billed with a telehealth modifier if the procedure code is not a covered telehealth service; and
- deny payment for distant-site claims from institutional facilities, except MNT services, unless the distant site is a CAH that has elected the Method II payment option, and the practitioner has reassigned his or her benefits to the CAH.

There is no claim payment edit that considers the beneficiary's geographic location at the time the telehealth service is provided. According to CMS officials, edits cannot be based on patient location unless a new field is added to telehealth claim forms.

¹² CMS. "Telehealth Services." Available online at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf>. Accessed on March 9, 2017.

¹³ CMS. "Telehealth." Available online at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/>. Accessed on March 9, 2017.

¹⁴ Health Resources and Services Administration. "Medicare Telehealth Payment Eligibility Analyzer." Available at <https://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx>. Accessed on March 9, 2017.

HOW WE CONDUCTED THIS REVIEW

We reviewed 191,118 Medicare paid distant-site telehealth claims from calendar years 2014 and 2015 that did not have corresponding originating-site claims. These claims had payments totaling \$13,795,384. We audited a stratified random sample of 100 claims. We obtained supporting documentation and reviewed it to determine whether paid telehealth services were allowable in accordance with Medicare requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains the Federal requirements related to Medicare telehealth.

FINDINGS

CMS paid practitioners for some telehealth claims associated with services that did not meet Medicare requirements. For 69 of the 100 claims in our sample, telehealth services met Medicare requirements, but the remaining 31 claims¹⁵ did not meet Medicare requirements. Specifically:

- 24 claims were unallowable because the beneficiaries received services at nonrural originating sites that did not fall under the demonstration program exception,
- 7 claims were billed by ineligible institutional providers,
- 3 claims were for services provided to beneficiaries at unauthorized originating sites,
- 2 claims were for services provided by an unallowable means of communication,
- 1 claim was for a noncovered service, and
- 1 claim was for services provided by a physician located outside the United States.

On the basis of our sample results, we estimated that Medicare could have saved approximately \$3,699,848 during our audit period if practitioners had provided telehealth services in accordance with Medicare requirements.

¹⁵ The total number of errors exceeds 31 because some claims were unallowable for more than 1 reason.

The deficiencies that we identified occurred because CMS did not ensure that (1) oversight existed to disallow payments for errors in which telehealth claim edits could not be implemented, (2) all contractor claim edits were in place, and (3) practitioners were aware of Medicare telehealth requirements. Practitioner education and improved monitoring would help ensure that paid telehealth services meet Medicare requirements.

BENEFICIARIES RECEIVED SERVICES AT NONRURAL ORIGINATING SITES

Federal regulations (42 CFR § 410.78(b)(4)) require originating sites, with the exception of entities participating in Federal telemedicine demonstration projects, to be located in either (1) an HPSA that is outside of an MSA as of December 31 of the preceding calendar year or within a rural census tract of an MSA, as determined by the Federal Office of Rural Health Policy (FORHP),¹⁶ as of December 31 of the preceding calendar year, or (2) a county that is not included in an MSA as of December 31 of the preceding year.

For 24 claims, beneficiaries received services in nonrural settings at sites that were not participating in a demonstration program. In one example, a patient's originating site was a physician's office in Lynchburg, Virginia, which is within an MSA. The results of the Medicare Telehealth Payment Eligibility Analyzer for each of these 24 originating-site locations indicated that "the address provided is not eligible for Medicare telehealth payment." Because the analyzer results were calendar-year specific and obtained after our audit period, we used core-based statistical area (CBSA)¹⁷ files to verify that these originating sites were within MSAs for the applicable claim calendar year.

SOME INSTITUTIONAL PROVIDERS WERE INELIGIBLE TO BILL FOR TELEHEALTH SERVICES

The Manual (chapter 12, § 190.6.1) permits distant-site practitioners to bill telehealth services to Medicare. Institutional facilities at a distant site may bill Medicare for telehealth services only when they meet one of two exceptions: (1) the facility is a CAH that elected the Method II payment option and the practitioner reassigned his or her benefits to the CAH or (2) the facility provided MNT services.

For seven claims, institutional providers billed outpatient claims for telehealth services performed at distant sites for beneficiaries located at rural originating sites, but the distant sites were not CAHs, and the services provided were not MNT services.

¹⁶ The FORHP advises the Secretary of Health and Human Services on health care issues affecting rural communities.

¹⁷ A CBSA is a statistical geographic entity consisting of the county or counties associated with at least one core (urbanized area or urban cluster) of at least 10,000 people plus adjacent counties that have a high degree of social and economic integration with the core as measured by commuting ties with counties containing the core. 75 Fed. Reg. 37246, 37251 (June 28, 2010).

BENEFICIARIES RECEIVED SERVICES AT UNAUTHORIZED ORIGINATING SITES

Telehealth services must be furnished to a beneficiary at an eligible originating site, which is one of the following: the office of a practitioner, a hospital, a CAH, a rural health clinic, a federally qualified health center, a hospital-based or CAH-based renal dialysis center, a skilled nursing facility, or a community mental health center (42 CFR § 410.78(b)(3)). Independent renal dialysis facilities are not eligible originating sites.

For three claims, the beneficiary locations were 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.

PRACTITIONERS USED AN UNALLOWABLE MEANS OF COMMUNICATION

In general, practitioners must provide telehealth services using an interactive telecommunications system (42 CFR § 410.78(b)), which does not include telephone, fax, or email (42 CFR § 410.78(a)(3)); however, CMS regulations (42 CFR § 410.78(d)) provide for an exception allowing for the use of asynchronous store and forward technology for Federal telemedicine demonstration programs in Alaska or Hawaii. For store and forward telehealth services, the distant-site practitioners must bill the services with the GQ modifier. By using the GQ modifier, the distant-site practitioner certifies that the medical file was collected and transmitted to the distant site from a Federal telemedicine demonstration project in Alaska or Hawaii.

For two claims, the practitioners used an unallowable means of communication. For one claim, the telehealth service was provided using an asynchronous store and forward telecommunications system. However, the originating site was not a Federal telemedicine demonstration project in Alaska or Hawaii. For the other claim, the service was provided by telephone rather than an interactive telecommunications system.

A PRACTITIONER PROVIDED A NONCOVERED SERVICE

Changes to the list of Medicare telehealth services are made through the annual physician fee schedule rulemaking process (42 CFR § 410.78(f)). Effective January 1, 2015, the CMS website lists allowable telehealth services and corresponding HCPCS codes. One practitioner provided a crisis psychotherapy service in CY 2015 using telehealth technology even though that service was not on the approved list of telehealth services.

A PRACTITIONER WAS LOCATED OUTSIDE THE UNITED STATES

In general, Medicare payment is not allowed for services provided outside the United States.¹⁸ The *Medicare Benefit Policy Manual* states that the professional services of a physician are covered if provided within the United States.¹⁹

For one claim, 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.

CAUSES OF UNALLOWABLE TELEHEALTH CLAIMS

Medicare Contractors Could Not Implement Edits for Some Errors

The majority of our findings related to claims for unallowable geographic locations of the originating sites, for which no oversight exists. The MACs could not implement edits for these types of errors because the claim form did not have a designated field for the originating-site location. CMS officials stated that adding such a field would be impractical because practitioners use the same claim form for non-telehealth claims, which do not need the field. Claim payment edits would also not detect other errors, such as if a practitioner used an unallowable means of communication. Without applicable MAC edits, other means of monitoring telehealth services, such as postpayment reviews, would be necessary to detect claims that do not meet Medicare telehealth requirements.

Contractor Claim Processing Edits Were Not Implemented

Some edits outlined in the Manual (chapter 12, § 190.7) were not implemented by the MACs. For example, we found that an edit to deny particular institutional claims was not in place. As a result, seven of eight institutional claims were for non-MNT services or for institutions other than CAHs. Also, a physician billed for one claim that was a noncovered telehealth service. These errors could have been detected if MACs had implemented the claim edits listed in the Manual and on page 4 of this report.

Several Practitioners Were Not Aware of Requirements

Several practitioners told us that they were not aware of specific Medicare telehealth requirements. Increasing practitioner awareness can be accomplished through training practitioners on telehealth requirements and related online resources. Although CMS issues telehealth guidance, CMS currently does not offer telehealth training to practitioners.

¹⁸ Section 1862(a)(4) of the Social Security Act and 42 CFR § 411.9(a).

¹⁹ Pub. No. 100-02, chapter 15, section 30.A.

RECOMMENDATIONS

We recommend that CMS take the following actions, which we estimate could have saved approximately \$3,699,848 for calendar years 2014 and 2015:

- conduct periodic postpayment reviews to disallow payments for errors for which telehealth claim edits cannot be implemented (for example, unallowable originating sites or unallowable means of communication);
- work with MACs to implement all telehealth claim edits listed in the Manual; and
- offer education and training sessions to practitioners on Medicare telehealth requirements and related resources.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described corrective actions it had taken or planned to take. CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding technical comments, appear in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed 191,118 paid Medicare distant-site telehealth claims for calendar years 2014 and 2015 that did not have corresponding originating-site claims. We limited our internal control review to testing specific MAC edits in the Manual (chapter 12, section 190.7).

We conducted fieldwork from October 2016 through February 2017.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- obtained all 2014 and 2015 telehealth claim data that had either HCPCS code Q3014 or code modifiers GT or GQ;
- determined which paid claims with distant-site GT or GQ modifiers had no matching payments, by enrollee and date of service, to originating sites;
- selected a stratified random sample of 100 claims (Appendix B);
- sent distant-site practitioners a letter requesting information related to their sampled claim(s), which included:
 - any policies or procedures related to providing telehealth services to patients,
 - a brief description of the professional service provided and the communication means used to provide the service,
 - the location of the practice from which the service was provided,
 - the location of the beneficiary when the service was provided,
 - the distant-site practitioner's specialty and any documentation showing that the practitioner was licensed under State law for the service provided, and
 - any claim detail to support the service provided;
- contacted originating-site providers as necessary to verify that the beneficiary was present on the date of service at their facilities;

- input originating-site addresses into the Medicare Telehealth Payment Eligibility Analyzer to determine whether these locations were rural or otherwise geographically eligible to provide telehealth services;
- matched originating-site zip codes to a zip-to-CBSA crosswalk²⁰ and then to previous county-to-CBSA crosswalks^{21,22} to verify whether originating sites were located within an MSA as of December 31 of the calendar year preceding the claim date of service;
- reviewed supporting documentation for sampled claims and questioned costs associated with distant-site claims if:
 - the service was not initiated from an eligible originating site;
 - the originating site was not (1) located in a rural HPSA as determined by the FORHP, (2) located outside an MSA, or (3) participating in a Federal telemedicine demonstration project;
 - the institutional facility's distant site (1) was not a CAH that had elected payment Method II and the practitioner had reassigned his or her benefits to the CAH or (2) did not provide an MNT service but billed the telehealth service as an outpatient institutional claim;
 - the individual providing the service was not an authorized practitioner;
 - the service was not provided through an allowable means, such as an interactive telecommunications system;
 - any service was billed with a telehealth modifier that was not a covered telehealth service;
 - the service was provided outside the United States; or
 - there was a lack of support that the telehealth service was performed;

²⁰ U.S. Department of Housing and Urban Development. "ZIP-CBSA Crosswalk File." Available online at https://www.huduser.gov/portal/datasets/usps_crosswalk.html. Accessed on February 17, 2016.

²¹ CMS. "2014 County to CBSA Crosswalk File." Available online at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/fy-2014-ipps-final-rule-home-page-items/fy-2014-ipps-final-rule-cms-1599-f-data-files.html>. Accessed on January 26, 2017.

²² CMS. "2015 County to CBSA Crosswalk File." Available online at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Data-Files.html>. Accessed on February 17, 2016.

- estimated the total cost savings on the basis of unallowable Medicare telehealth claims (Appendix C); and
- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of Medicare-paid distant-site telehealth claims that used modifier GT or GQ and had no matching originating-site telehealth claim (HCPCS code Q3014) for services provided from January 1, 2014, through December 31, 2015.

SAMPLING FRAME

The sampling frame was an Access database file containing Medicare telehealth claims (HCPCS code Q3014 or modifier GT or GQ) with dates of service in calendar years 2014 and 2015. The file contained 561,487 Medicare telehealth claims totaling \$26,810,937.

To refine our sampling frame and limit our scope, we excluded:

- claims associated with practitioners who were under investigation by the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Investigations;
- claims with payment amounts of \$0, leaving only paid claims;
- originating-site claims (code Q3014), leaving only paid distant-site claims;
- paid distant-site claims that matched the now-separate paid originating-site claims by both beneficiary and date of service;
- one claim associated with an invalid national provider identifier; and
- claims with payments of less than \$1.

This resulted in a sampling frame of 191,118 Medicare paid distant-site telehealth claims for services provided from January 1, 2014, through December 31, 2015, totaling \$13,795,384.

SAMPLE UNIT

The sample unit was an individual Medicare paid claim for a distant-site telehealth service.

SAMPLE DESIGN

We used a stratified random sample, defined as follows:

Table 1: Sample Design

Stratum	Range of Claim Payment Amount	Number of Claims	Amount of Payments
1	\$1 through \$73.99	119,467	\$5,582,229
2	\$74 through \$6,107	71,651	8,213,155
Total		191,118	\$13,795,384

SAMPLE SIZE

We selected and reviewed a random sample of 40 claims from stratum 1 and 60 claims from stratum 2.

SOURCE OF RANDOM NUMBERS

We used the OIG, Office of Audit Services (OAS), statistical software to generate the random numbers.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the point estimate and a two-sided 90-percent confidence interval for the total dollar amount of improper Medicare distant telehealth claims in the sampling frame.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Claims	Value of Unallowable Claims
1	119,467	\$5,582,229	40	\$1,686	12	\$441
2	71,651	8,213,155	60	6,467	19	1,994
Total	191,118	\$13,795,384	100	\$8,153	31	\$2,436²³

**Table 3: Estimated Value of Unallowable Telehealth Claims
(Limits Calculated for a 90-percent Confidence Interval)**

Point estimate	\$3,699,848
Lower limit	2,693,774
Upper limit	4,705,923

²³ The value of unallowable claims for each stratum does not sum to the sample total due to rounding.

APPENDIX D: FEDERAL REQUIREMENTS

FEDERAL REQUIREMENTS FOR TELEHEALTH ORIGINATING SITES

Federal regulations (42 CFR § 410.78(b)(3)) require that telehealth services be furnished to a beneficiary at an originating site, which is one of the following: the office of a physician or practitioner, a hospital, a CAH, a rural health clinic, a federally qualified health center, a hospital-based or CAH-based renal dialysis center, a skilled nursing facility, or a community mental health center. The Manual (chapter 12, § 190.2) states that independent renal dialysis facilities are not eligible originating sites.

Federal regulations (42 CFR § 410.78(b)(4)) state that an originating site must be (1) located in a health professional shortage area that is either outside of an MSA as of December 31 of the preceding calendar year or within a rural census tract of an MSA, as determined by the FORHP, as of December 31 of the preceding calendar year; (2) located in a county that is not included in an MSA, as defined in section 1886(d)(2)(D) of the Act as of December 31 of the preceding year; or (3) an entity participating in a Federal telemedicine demonstration project that has been approved by, or receiving funding from, the Secretary of Health and Human Services as of December 31, 2000, regardless of its geographic location.

FEDERAL REQUIREMENTS FOR TELEHEALTH DISTANT-SITE PRACTITIONERS

Federal regulations (42 CFR § 410.78(b)(2)) state that practitioners at the distant site who may furnish and receive payment for covered telehealth services are physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists, clinical social workers, and registered dietitians or nutrition professionals.²⁴ Federal regulations (42 CFR § 410.78(b)(1)) state that the physician or practitioner at the distant site must be licensed to furnish the service under State law. The Manual (chapter 12, § 190.7) states that the claims contractor must install edits to ensure that only properly licensed physicians and practitioners are paid for covered telehealth services.

The Manual (chapter 12, § 190.6.1) states that physicians/practitioners must submit the appropriate procedure codes for covered professional telehealth services along with the GT modifier (“via an interactive audio and video telecommunications system”). By coding and billing the GT modifier with a covered telehealth procedure code, the distant-site physician/practitioner certifies that the beneficiary was present at an eligible originating site

²⁴ Effective January 1, 2016, which is after our audit period, CMS added certified registered nurse anesthetists to the list of practitioners at a distant site who may receive payment for covered telehealth services. 80 Fed. Reg. 70886, 71373 (Nov. 16, 2015) (adding paragraph 42 CFR § 410.78(b)(2)(ix)).

when the telehealth service was furnished.²⁵ Section 190.6.2 states that by using the GQ modifier (“via asynchronous telecommunications system”), distant-site physicians/practitioners certify that the asynchronous medical files were collected and transmitted to them at their distant sites from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

FEDERAL REQUIREMENTS FOR TELEHEALTH INSTITUTIONAL PROVIDERS AT DISTANT SITES

Federal regulations (42 CFR § 414.65(a)(2)) state that only the practitioner at the distant site may bill and receive payment for a professional service provided through an interactive telecommunications system. However, under certain limited circumstances, the Manual permits institutional providers to bill for telehealth services provided at the distant sites. The Manual (chapter 12, § 190.6(3)) states that if the physician or practitioner at the distant site is located in a CAH that has elected the Method II payment option, and the physician or practitioner has assigned his or her benefits to the CAH, the CAH bills its regular MAC for the professional services provided at the distant site through a telecommunications system.²⁶ The Manual (chapter 12, § 190.7) states that, except for MNT services, the only claims from institutional facilities that the MACs may pay for telehealth services at the distant site are for physician or practitioner services when the distant site is located in a CAH that has elected Method II and the physician or practitioner has reassigned his or her benefits to the CAH. The Manual (chapter 12, § 190.7) states that claims from hospitals or CAHs for MNT services are submitted to the hospital’s or CAH’s regular MAC.

FEDERAL REQUIREMENTS FOR ALLOWABLE TELEHEALTH SERVICES

Federal regulations (42 CFR § 410.78(f)) state that changes to the list of Medicare telehealth services are made through the annual physician fee schedule rulemaking process. Effective January 1, 2015, Federal regulations (42 CFR § 410.78(f)) also state that a list of the services covered as telehealth services is available on the CMS website.²⁷ Prior to January 1, 2015, the Manual (chapter 12, § 190.3) listed the various allowable services and corresponding Current Procedural Terminology or HCPCS codes. The Manual (chapter 12, § 190.7) states that if a service is billed with one of the telehealth modifiers and the procedure code is not designated as a covered telehealth service, the MAC denies the service.

²⁵ Effective January 1, 2018, which was after our audit period, use of the GT modifier on professional claims for telehealth services was eliminated. By billing place-of-service code 02 with a covered telehealth procedure code, the distant site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. While the GT modifier was eliminated for use on professional claims, it was retained for use on institutional claims. (The Manual (chapter 12, § 190.6.1) as amended by Transmittal 3929, Change Request 10152, dated November 29, 2017).

²⁶ Prior to Transmittal 3476, Change Request 9428, dated March 11, 2016, and effective January 1, 2015, this provision was located at the Manual, chapter 12, § 190.5(3).

²⁷ 79 Fed. Reg. 67548, 68002 - 3 (Nov. 13, 2014). CMS. “List of Telehealth Services.” Available online at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html>. Accessed on October 5, 2017.

FEDERAL REQUIREMENTS FOR ALLOWABLE MEANS OF COMMUNICATION FOR TELEHEALTH SERVICES

Federal regulations (42 CFR § 410.78(b)) state that Medicare Part B pays for covered telehealth services included on the telehealth list when furnished through an interactive telecommunications system, which does not include telephones, facsimile machines, or electronic mail systems (42 CFR § 410.78(a)(3)). The Manual (chapter 12, § 190.4(1)) states that for Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant-site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

Federal regulations (42 CFR § 410.78(d)) allow for an exception to the interactive telecommunications system requirement. For Federal telemedicine demonstration programs conducted in Alaska or Hawaii only, Medicare payment is permitted for telehealth when asynchronous store and forward technologies, in single or multimedia formats, are used as a substitute for an interactive telecommunications system. The Manual (chapter 12, § 190.4(3)) states that for purposes of this instruction, “store and forward” means the asynchronous transmission of medical information to be reviewed at a later time by a physician or practitioner at the distant site. The Manual (chapter 12, § 190.6.2) states that covered store and forward telehealth services are billed with the GQ modifier (“via an asynchronous telecommunications system”).

FEDERAL REQUIREMENTS FOR SERVICES PROVIDED OUTSIDE THE UNITED STATES

The Social Security Act (§ 1862(a)(4)) states that notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services that are not provided within the United States. Federal regulations (42 CFR § 411.9(a)) state that except as specified in paragraph (b),²⁸ Medicare does not pay for services furnished outside the United States. The *Medicare Benefit Policy Manual*, Pub. No. 100-02 (chapter 15, § 30.A), states that professional services of the physician are covered if provided within the United States.

²⁸ 42 CFR § 411.9(b) allows an exception for payment for covered inpatient services furnished in a foreign hospital and for covered physicians’ services and ambulance service furnished in connection with those inpatient services.

APPENDIX E: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

FEB 2 2018

DATE:

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma *SV*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements (A-05-16-00058)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to strengthening access to care, especially for those living in rural areas, while protecting taxpayer dollars by preventing improper payments.

CMS is expanding the services that can be provided as Medicare telehealth services and reducing the administrative burden for health care providers to bill for these services. Improving access to telehealth services reflects CMS's work to modernize Medicare payments to promote patient-centered innovations. Telehealth services are intended to connect Medicare beneficiaries located in rural areas to medically necessary services they may otherwise not have access to. For Medicare telehealth services, the use of a telecommunications system substitutes for an in-person encounter. Telehealth services, such as consultations, office visits, individual psychotherapy, or pharmacologic management may be furnished to a Medicare beneficiary at an originating site meeting statutory requirements by a physician or other practitioner authorized by statute at a distant site.

CMS recognizes the importance of continuing to provide Medicare beneficiaries with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. CMS has taken actions to prevent improper Medicare payments by educating health care providers on proper billing, including billing for telehealth services. CMS educates health care providers on avoiding Medicare billing errors through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS conduct periodic postpayment reviews to disallow payments for errors for which telehealth claim edits cannot be implemented (for example, unallowable originating sites or unallowable means of communication).

CMS Response

CMS concurs with this recommendation. As part of the Comprehensive Error Rate Testing Program, which CMS uses to calculate the annual improper payment rate in the Medicare Fee-For-Service program, CMS reviews a sample of telehealth claims. As part of this process, medical review professionals perform complex medical review of documentation submitted to support the claim to determine whether the claim was paid properly under Medicare coverage, coding, and billing rules.

OIG Recommendation

The OIG recommends that CMS work with MACs to implement all telehealth claim edits listed in the Manual.

CMS Response

CMS concurs with this recommendation. CMS will continue to work with the MACs to implement all telehealth claims edits listed in the Manual.

OIG Recommendation

The OIG recommends that CMS offer training sessions to practitioners on Medicare telehealth requirements and related resources.

CMS Response

CMS concurs with this recommendation. CMS routinely educates practitioners through various channels, including the Medicare Learning Network, weekly electronic newsletters and quarterly compliance newsletters. CMS will continue to use channels such as these to educate and provide training sessions for practitioners on Medicare telehealth requirements and related resources.