



Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks

Key Takeaways

- Our findings demonstrate the importance of effective, targeted oversight of telehealth services to ensure that the benefits of telehealth are realized while minimizing risk.
- We identified 1,714 providers out of approximately 742,000 whose billing for telehealth services poses a high risk to Medicare.
- Each of these providers had concerning billing on at least one of seven measures that may indicate fraud, waste, or abuse.
- These providers billed for telehealth services for about half a million beneficiaries.
- Many of these providers are a part of the same medical practice as at least one other provider whose billing poses a high risk.

Why OIG Did This Review

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries access health care. In response, the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries.¹ In addition, CMS temporarily paused several program integrity activities, including medical reviews of claims.²

In a related report, the Office of Inspector General (OIG) found that the use of telehealth increased dramatically during the first year of the pandemic.³ More than 28 million Medicare beneficiaries—about 2 in 5—used telehealth services that first year. In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they did in the prior year.

The changes to Medicare telehealth policies, along with the dramatic increase in the use of telehealth, underscore the importance of determining whether providers are billing for telehealth services appropriately and how to best protect Medicare and beneficiaries against fraud, waste, and abuse.

This data brief describes providers' billing for telehealth services and identifies ways to safeguard Medicare from fraud, waste, and abuse related to telehealth. This information can help CMS, Congress, and other stakeholders determine what safeguards may be needed as they consider permanent changes to telehealth policies in Medicare.

This report is part of a series that examines the use of telehealth in Medicare and the characteristics of beneficiaries who used telehealth during the pandemic.⁴

How OIG Did This Review

This data brief is based on an analysis of Medicare fee-for-service claims data and Medicare Advantage encounter data for the first year of the pandemic from March 1, 2020, to February 28, 2021. We focused our analysis on the approximately 742,000 providers who billed for a telehealth service. Using input from OIG investigators, we developed seven measures that focus on different types of billing for telehealth services that may indicate fraud, waste, or abuse. For each of these measures, we set very

high thresholds to identify providers whose billing poses a high risk to Medicare. Because this data brief focuses on specific measures with very high thresholds, it does not capture all concerning billing related to telehealth services that may be occurring in Medicare. Additionally, this report does not confirm that any particular provider is engaging in fraudulent or abusive practices. Any determination of fraud or an overpayment would require additional investigation.

Further, a Medicare billing practice—known as “incident to” billing—creates challenges for oversight because it allows services provided by clinical staff who are directly supervised by a practitioner to be billed under the supervising practitioner’s identification number. It is critical for program integrity efforts to identify the individual who delivered the telehealth service that is billed to Medicare. To address these limitations in the data, we developed measures for this report that aim to minimize the effect of “incident to” billing on the results of the claims analysis.

What OIG Found

We identified 1,714 providers whose billing for telehealth services during the first year of the pandemic poses a high risk to Medicare. These providers billed for telehealth services for about half a million beneficiaries. They received a total of \$127.7 million in Medicare fee-for-service payments.

Each of these 1,714 providers had concerning billing on at least 1 of 7 measures we developed that may indicate fraud, waste, or abuse of telehealth services. All of these providers warrant further scrutiny. For example, they may be billing for telehealth services that are not medically necessary or were never provided.

In addition, more than half of the high-risk providers we identified are a part of a medical practice with at least one other provider whose billing poses a high risk to Medicare. This may indicate that certain practices are encouraging such billing among their associated providers. Further, 41 providers whose billing poses a high risk appear to be associated with telehealth companies; however, there is currently no systematic way to identify these companies in the Medicare data.

What OIG Recommends

Although these high-risk providers represent a small proportion of all providers who billed for a telehealth service, these findings demonstrate the importance of strong, targeted oversight of telehealth services. The findings also offer insight on how Medicare and others can protect beneficiaries against fraud, waste, and abuse. Conducting targeted oversight of telehealth will help ensure the benefits of telehealth are realized while minimizing risk in an effective and efficient manner. Accordingly, we recommend that CMS: (1) strengthen monitoring and targeted oversight of telehealth services, (2) provide additional education to providers on appropriate billing for telehealth services, (3) improve the transparency of “incident to” services when clinical staff primarily delivered the telehealth service, (4) identify telehealth companies that bill Medicare, and (5) follow up on the providers identified in this report. CMS concurred with our recommendation to follow up on the providers identified in this report, but CMS did not explicitly indicate whether it concurred with the other four recommendations.

- ▶ **Medicare telehealth services** refer to services that are provided remotely using technology between a provider and a beneficiary.⁵
- ▶ The services that can be provided via telehealth include **office visits**, **behavioral health services**, **nursing home visits**, and **home visits**, among others. Most of these services can also be provided in person. (See Appendix A for a description of these services.)
- ▶ A group of services known as **virtual care services** is **always provided remotely**.⁶ An example of these services is a telephone call with a provider to discuss a beneficiary's medical condition.
- ▶ During the pandemic, CMS allowed beneficiaries to use telehealth to access a wide range of services in different locations, including in **urban areas and from the beneficiary's home**. Prior to the pandemic, beneficiaries were allowed to use telehealth only from medical facilities located in rural areas, with a few exceptions.⁷
- ▶ During the pandemic, CMS increased the types of services that beneficiaries could use via telehealth, from 118 to **264 services**.⁸ Medicare pays providers the same rate for services provided via telehealth and in person.
- ▶ During the pandemic, CMS expanded the use of **audio-only** for certain types of telehealth services, such as office visits and behavioral health services. Prior to the pandemic, only audio-video was allowed for the delivery of telehealth services, with a few exceptions.⁹

RESULTS

This data brief describes providers' billing for telehealth services during the first year of the pandemic and identifies ways to safeguard Medicare from fraud, waste, and abuse related to telehealth. Each of the providers identified in this report had concerning billing on at least one of seven measures we developed that may indicate fraud, waste, or abuse. (See Exhibit 1.) For each measure, we set very high thresholds to identify providers who had concerning billing. Because this data brief focuses on specific measures with very high thresholds, it does not capture all concerning billing related to telehealth services that may be occurring in Medicare.

The seven measures that we developed focus on different types of billing for telehealth services that may indicate fraud, waste, or abuse. Some of these billing practices also occur with in-person services, such as always billing for the most expensive codes. These measures do not include telemarketing fraud that does not involve billing for telehealth services. Telemarketing fraud—often referred to as telefraud—generally involves a phone call or other remote interaction with a beneficiary to order or prescribe medically unnecessary testing, equipment, or prescriptions.¹⁰ This data brief is based on Medicare fee-for-service claims data and Medicare Advantage encounter data for the first year of the pandemic—from March 1, 2020, to February 28, 2021.¹¹

Exhibit 1: Program Integrity Measures

To identify providers whose billing for telehealth services poses a high risk to Medicare, we developed seven measures based on analyses of the Medicare data and input from OIG investigators. These measures focus on different types of billing that providers may use to inappropriately bill for telehealth services and include:

- ▶ billing both a **telehealth service** and a **facility fee** for most visits;
- ▶ billing telehealth services at the **highest, most expensive level** every time;
- ▶ billing telehealth services for a **high number of days** in a year;
- ▶ billing both **Medicare fee-for-service** and a **Medicare Advantage plan for the same service** for a high proportion of services;
- ▶ billing a **high average number of hours** of telehealth services per visit;
- ▶ billing telehealth services for a **high number of beneficiaries**; and
- ▶ billing for a telehealth service and **ordering medical equipment** for a high proportion of beneficiaries.

More than 1,700 providers billed for telehealth services in a manner that poses a high risk to Medicare

In total, we identified 1,714 providers whose billing for telehealth services during the first year of the pandemic posed a high risk to Medicare. Each of these providers had concerning billing on at least one of seven measures we developed that may indicate fraud, waste, or abuse of telehealth services. Although these providers represent a small proportion of the approximately 742,000 providers who billed for a telehealth service, their billing raises concern.

These seven measures focus on different types of billing that providers may use to inappropriately maximize their Medicare payments. For each of these measures, we set very high thresholds to identify providers who had concerning billing. There could be additional providers with concerning billing that fell below our thresholds. Additionally, this report does not confirm that a particular provider is engaging in fraudulent or abusive practices. Any determination of fraud or an overpayment would require additional investigation.

The vast majority (1,696) of the providers we identified had concerning billing on 1 of the 7 measures, while 18 providers had concerning billing on 2 measures. Each of these 1,714 providers warrant further scrutiny. They may be billing for telehealth services that are not medically necessary or were never provided. Their billing also raises concerns about the quality of services being provided.¹²

In total, these 1,714 providers billed for telehealth services for about half a million beneficiaries. They received a total of \$127.7 million in Medicare fee-for-service payments.¹³ This amount—and all dollar amounts in this report—are those paid by Medicare fee-for-service only; the amounts paid by Medicare Advantage plans to providers are not reported to Medicare.

Providers Whose Billing Poses a High Risk to Medicare

- Billed telehealth services for **about half a million beneficiaries**.
- Received a total of **\$127.7 million** in Medicare fee-for-service payments.

In addition, multiple providers with concerning billing are a part of the same medical practice. In total, 991 of the 1,714 providers are a part of the same medical practice as at least one other provider whose billing poses a high risk.¹⁴ This may indicate that certain practices encourage such billing among their associated providers.

Further, 41 providers who had concerning billing appear to be associated with telehealth companies—companies that employ practitioners to provide on-demand telehealth services to beneficiaries.¹⁵ Unlike other providers, telehealth companies do not offer in-person services. We identified providers who appear to be associated with a telehealth company by reviewing the name of the provider billing Medicare;

there is currently no systematic way to identify these companies in the Medicare data. These providers billed both Medicare fee-for-service and Medicare Advantage plans for telehealth services.

It is important to note that a Medicare billing practice—known as “incident to” billing—creates challenges for oversight. “Incident to” billing allows for services provided by clinical staff who are directly supervised by a practitioner to be billed under the supervising practitioner’s identification number. Identifying the individual who delivered the telehealth service that is billed to Medicare is critical to program integrity efforts. To address these limitations in the data, we developed measures for this report that aim to minimize the effect of “incident to” billing on the results of the claims analysis.

More than 670 providers billed inappropriately for both a telehealth service and a facility fee for most of their visits

A total of 672 providers billed for both a facility fee—also known as an originating site fee—and a telehealth service for more than 75 percent of their telehealth visits. A provider should not bill for both the facility fee and a telehealth service for the same visit.¹⁶

Billing for both would mean that the provider and beneficiary were at the same physical location when the telehealth service was provided; therefore, the provider is not allowed to deliver a telehealth service.¹⁷

Although some providers may be billing this way in error, others may be billing this way to inappropriately maximize their Medicare payments for each visit.

These 672 providers billed for both the facility fee and a telehealth service for about 148,000 visits, totaling more than \$14.3 million for facility fees and telehealth services. In total, 21 providers billed for both the facility fee and a telehealth service for more than 1,000 visits each. Further, 57 providers billed this way for all of their visits.

Billing for Telehealth Services

When a beneficiary receives a telehealth service in a facility—such as a hospital or physician’s office—from a physician or practitioner located at a separate location, the facility can charge Medicare a **facility fee** for hosting the telehealth service.

The **physician or practitioner** who provides the telehealth service **may not bill for the facility fee.**

Examples of providers who billed for both a facility fee and a telehealth service

Two providers—a psychiatrist and psychologist—billed for both a facility fee and a telehealth service for more than 90 percent of their visits, amounting to nearly 4,000 visits each. These providers billed facility fees and telehealth services totaling approximately \$1.1 million.

More than 360 providers always billed telehealth services at the highest, most expensive level

In total, 365 providers billed for certain telehealth services at the highest, most expensive level every time.¹⁸ Providers can bill certain services at different levels depending on the complexity of the beneficiary’s condition or the duration required to diagnose and treat a beneficiary.

Billing for the highest level of complexity or duration when that is not what was needed or provided is one scheme that unscrupulous providers use to inappropriately increase their Medicare payments. Payments for the highest level range from nearly two times to almost eight times more than the lowest level. This practice is often referred to as “upcoding.” In these cases, providers may be delivering higher levels of services than medically necessary or billing for levels of services that were not rendered.

Office visits provided via telehealth: In total, 170 providers always billed for office visits provided via telehealth at the highest, most expensive level possible. In contrast, most providers who billed for these types of visits never billed at the highest level. (See Appendix B for a description of the different levels of each of these types of services.)

These 170 providers billed for about 34,400 telehealth office visits, all at the highest level. Medicare fee-for-service payments for these visits totaled \$2.2 million. Two of these providers billed the highest level for more than 1,300 visits each.

In some cases, providers billing at the highest levels were concentrated in specific medical practices. In total, 21 medical practices had multiple providers who always billed at the highest level for telehealth office visits. In one case, a single medical practice had 30 providers who always billed at the highest level.

In addition to always billing at the highest level, 14 providers billed for additional time, prolonging the office visits past the highest level, for more than half of their visits.¹⁹ One provider billed this way for more than 90 percent of the provider’s

Office Visits

170 providers **always** billed at the highest level.

14 providers billed for prolonged services beyond the highest level for more than half of their visits.

telehealth office visits. Providers who bill for prolonged office visits that extend beyond the time at the highest level receive additional payment.

Other types of visits provided via

telehealth: An additional 195 providers always billed for other types of visits at the highest, most expensive level. These types of visits included home visits, nursing home visits, or assisted living visits that were provided via telehealth.²⁰ In contrast, most providers almost never billed the highest level for any of these services.

These 195 providers billed for about 40,300 visits, totaling almost \$3 million in Medicare fee-for-service payments. Five of these providers billed at the highest level for more than 1,000 visits each. One provider not only billed exclusively for the highest level possible of home visits, but also billed for additional time, prolonging the home visits past the highest level, for more than half of the visits.

Other Visits

140 providers **always** billed telehealth home visits at the highest level.

41 providers **always** billed telehealth nursing home visits at the highest level.

19 providers **always** billed telehealth assisted living visits at the highest level.

More than 320 providers billed for telehealth services for more than 300 days of the year

A total of 328 providers billed for telehealth services for more than 300 days of the year, which averages to more than 25 days per month for each provider. Each of these providers billed for telehealth services for many more days, compared to the median of 26 days of the year for all providers who billed for telehealth services.

Billing for telehealth for a high number of days may indicate that the provider may not be providing the services for which they are billing. The 328 providers who billed for telehealth services for more than 300 days received a total of \$65 million in Medicare fee-for-service payments. In some cases, these providers were concentrated in specific medical practices. Specifically, 96 of the 328 providers are a part of the same medical practice as at least one other provider who billed for more than 300 days.

Example of providers who billed for telehealth services for more than 300 days of the year

Two family medicine providers billed for telehealth services every single day from March 1, 2020, to February 28, 2021. Together, they billed for nearly 18,600 services for slightly more than 1,800 beneficiaries—averaging to more than 10 services for each beneficiary. They received nearly \$500,000 in Medicare fee-for-service payments.

Two other providers—who appear to be associated with the same telehealth company—billed for telehealth services every single day of the year. Together, these providers billed for approximately 76,000 services for slightly more than 4,300 beneficiaries—averaging to more than 17 services for each beneficiary. They received more than \$1.4 million in Medicare fee-for-service payments.

More than 130 providers repeatedly billed Medicare fee-for-service and a Medicare Advantage plan for the same telehealth service

A total of 138 providers billed both Medicare fee-for-service and a Medicare Advantage plan for the same telehealth service for more than 20 percent of their telehealth services.²¹ Repeatedly billing both Medicare programs for the same service may indicate that providers are intentionally submitting duplicate claims to increase their Medicare payments.

These 138 providers billed both programs for more than 9,000 telehealth services. Of note, three providers billed both Medicare fee-for-service and a Medicare Advantage plan for at least 90 percent of their telehealth services.

More than 80 providers billed for a high average number of hours of telehealth services per visit

In total, 86 providers billed for an average of more than 2 hours of telehealth services per visit. This is far higher than the median of 21 minutes of telehealth services per visit for all providers who billed for telehealth services.

When providers bill for a high average number of hours of telehealth services per visit, they may be billing for unnecessary services or for services not rendered.²² This is one method that unscrupulous providers use to inappropriately maximize their Medicare payments.²³

Notably, 10 providers billed an average of 3 or more hours per visit—more than 8 times the average for a telehealth visit. One provider, a psychologist, billed 3 or more

hours for more than 150 visits. On one occasion, this provider billed for 10 hours for a single visit for one beneficiary.

Many of the providers who billed for a high average number of hours of telehealth services per visit billed for the same service multiple times during a single visit. These providers commonly billed for multiple psychotherapy or rehabilitation sessions for the same patient in a single day. For example, nine providers each billed five or more times for psychotherapy for several visits. This may indicate that these providers are inappropriately maximizing Medicare payments by billing for services not provided or providing unnecessary services.

Example of a provider who billed for a high number of hours of telehealth services per visit

One mental health counselor billed an average of nearly 4 hours per visit for 37 different visits. This provider also frequently billed the same psychotherapy service eight times per visit. This provider and six other providers who billed a high number of hours worked for the same chain of mental health and substance use recovery facilities in Florida.

More than 70 providers billed for telehealth services for a high number of beneficiaries

These 76 providers each billed for telehealth services for at least 2,000 beneficiaries in a year. This is far above the median of 21 beneficiaries for all providers who billed for telehealth services. These providers billed for more than 1.7 million telehealth services, totaling nearly \$57.5 million in Medicare fee-for-service payments. They most commonly billed for office visits and audio-only services.

Two of these providers, who appear to be associated with the same telehealth company, each billed for more than 10,000 beneficiaries. One of these providers billed for more than 27,400 beneficiaries—an average of 75 beneficiaries a day if the provider rendered services every single day for a year. Another provider, who did not appear to be associated with a telehealth company, billed for more than 4,400 beneficiaries. For this to occur, this provider would need to see an average of 12 new beneficiaries every single day for a year.

It is highly improbable that these providers rendered telehealth services to, or were available to supervise telehealth services for, so many beneficiaries. Billing for a high number of beneficiaries may indicate that the provider is billing for services that were not provided. If these services were provided, this billing raises serious concerns about the quality of care.

In total, six medical practices were associated with multiple providers who billed for a high number of beneficiaries. In one case, six providers were a part of the same medical practice.

More than 60 providers commonly billed for telehealth services and then ordered medical equipment and supplies

In total, 67 providers billed for telehealth services and then ordered medical equipment and supplies for at least half of their beneficiaries. This is far higher than the median of 3 percent for all providers.²⁴ Billing medical equipment and supplies for a high percentage of beneficiaries raises concern, as this practice has been linked to known fraud schemes.

In total, these 67 providers billed for telehealth services and ordered medical equipment and supplies that amounted to a total of more than \$28 million from Medicare fee-for-service. These providers may be ordering unnecessary medical equipment and supplies for beneficiaries. For example, providers may be billing for telehealth services, regardless of whether a beneficiary was ever contacted, and ordering medical equipment and supplies as part of a kickback scheme with suppliers. Of note, most of these providers specialized in internal or family medicine.

There is added concern when providers order medical equipment and supplies primarily for beneficiaries with whom they do not have an established relationship. During the pandemic, the requirement for an in-person visit with the beneficiary before ordering medical equipment and supplies was waived in most instances.²⁵ Notably, seven providers ordered medical equipment and supplies solely for beneficiaries with whom they had no established relationship. This billing pattern may indicate that these providers are billing for telehealth services and ordering medical equipment and supplies using stolen or compromised beneficiary identifiers.

Additionally, six providers billed primarily for audio-only telehealth services before ordering medical equipment and supplies for beneficiaries. This may indicate that providers are cold calling new beneficiaries to increase orders for medical equipment, supplies, and telehealth services.²⁶ In 2021 and 2022, OIG and other law enforcement partners uncovered alleged kickback schemes that involved telehealth companies partnering with durable medical equipment companies to commit Medicare fraud.²⁷ In some instances, the providers allegedly billed Medicare for telehealth services that did not occur.

Examples of providers who billed for telehealth services and then ordered medical equipment and supplies

One physician billed for telehealth and then ordered medical equipment and supplies for more than 400 beneficiaries, representing nearly 78 percent of their beneficiaries. This physician ordered 109 different types of medical equipment and supplies, totaling more than \$9 million. The physician did not have an established relationship with any of the 400 beneficiaries and appeared to provide services through a telehealth company.

CONCLUSION AND RECOMMENDATIONS

The changes to Medicare telehealth policy, along with the dramatic increase in the use of telehealth, underscore the importance of determining whether providers are billing for telehealth services appropriately and of identifying ways to safeguard the program against fraud, waste, and abuse.

We identified 1,714 providers whose billing for telehealth services during the first year of the pandemic poses a high risk to Medicare. Although these providers represent a small proportion of the approximately 742,000 providers who billed for a telehealth service, their billing raises concern. For example, they may be billing for telehealth services that are not medically necessary or were never provided.

These findings also highlight several ways that providers may inappropriately bill for telehealth services. Further, these findings shed light on potential methods for safeguarding the program and protecting beneficiaries specific to telehealth.

As permanent changes to telehealth are considered, it is essential that CMS, Congress, and other stakeholders incorporate targeted, appropriate safeguards to prevent, detect, and remediate the program integrity risks identified in this report. Currently, CMS is utilizing existing tools, such as pre- and post-payment edits and the Fraud Prevention System edits, to address program integrity risks associated with telehealth. Additionally, CMS is part of the Healthcare Fraud Prevention Partnership and meets with OIG investigators and the Department of Justice (DOJ) to discuss fraud trends and coordinate on certain cases of suspected fraud.²⁸ CMS also conducts provider interviews, beneficiary interviews, and medical reviews to determine whether services billed were medically necessary. However, the billing practices that we identified demonstrate the benefit and importance of strengthening targeted oversight of telehealth services to protect the Medicare program and beneficiaries against fraud, waste, and abuse.²⁹

We recommend that CMS:

Strengthen monitoring and targeted oversight of telehealth services

To effectively target program integrity efforts, CMS and its contractors should closely monitor telehealth services on an ongoing basis to identify providers who pose a risk to the program. CMS could use the measures in this report, and others it deems appropriate, when designing its claims analysis to strengthen its oversight of telehealth services. Further, as program integrity risks evolve, stakeholders can use these findings to inform future oversight efforts.

In addition, CMS currently sends reports to select providers that compare their number of claims for certain telehealth services to national and State averages.³⁰ CMS could incorporate additional measures into these provider reports based on the program integrity risks identified in this report. For example, it could include measures that focus on the extent to which providers bill for the highest, most expensive levels of certain telehealth services.

CMS should also conduct targeted reviews of providers identified through the measures we developed, or others it deems appropriate. These reviews could include close monitoring of providers' billing patterns and reviews of their medical records, as appropriate. These reviews could be used to recover inappropriate payments, to place certain providers on prepayment review, to initiate fraud investigations, or to develop additional claims processing edits, as necessary.

Provide additional education to providers on appropriate billing for telehealth services

The providers identified in this report billed in a manner that may indicate fraud, waste, or abuse. In addition to these providers, other providers billed for telehealth services inappropriately but did not exceed the high thresholds we set for these measures. For example, more than 18,000 providers billed both Medicare fee-for-service and a Medicare Advantage plan for the same telehealth service at least once. Additionally, more than 5,700 providers billed for both a telehealth service and a facility fee for the same visit at least once. One way to reduce inappropriate billing is to provide additional education to providers on how to correctly bill for telehealth services.

CMS should conduct additional educational outreach to providers. CMS should offer additional trainings and webinars on how to appropriately bill for telehealth services through its Medicare Learning Network. As a part of this outreach, CMS should include information such as when it is appropriate to bill an originating site facility fee and how to avoid billing Medicare fee-for-service and a Medicare Advantage plan for the same service.

Further, CMS should target specific providers with high levels of inappropriate billing for telehealth services and provide one-on-one education to them. These one-on-one training sessions should include a discussion with the provider about the telehealth services inappropriately billed and a review of CMS guidelines that should have been followed.

Improve the transparency of “incident to” services when clinical staff primarily delivered a telehealth service

Identifying the individual who delivered the telehealth service that is billed to Medicare is critical to program integrity efforts; however, this identification is not possible under Medicare’s current billing rules. “Incident to” billing allows services provided by clinical staff who are directly supervised by a physician or non-physician practitioner to be billed under the supervising practitioner’s identification number. Consequently, multiple individuals can provide telehealth services under a single identification number. This billing practice makes it difficult to determine when telehealth services were provided by the physician or when services were rendered “incident to” a physician.

Further, Medicare billing data would also not reveal whether an individual providing a service under a physician’s supervision had been terminated from Medicare or excluded from participation from Federal health care programs. In addition, prior OIG work found that “incident to” services provided in person were frequently delivered by practitioners who lacked the licenses, certifications, credentials, or training required for those services.³¹ It is important that CMS and oversight agencies are able to determine which provider rendered a telehealth service to a beneficiary.

For this reason, CMS should require the use of a modifier to indicate “incident to” telehealth services when clinical staff primarily delivered the service billed under the supervising practitioner’s identification number. To do so, CMS should create a service code modifier. CMS should require that providers use this modifier on Medicare fee-for-service claims and Medicare Advantage encounters to identify “incident to” telehealth services.

In addition to the modifier, CMS should also take steps to allow providers to report the identification number of the clinical staff who primarily delivered the service, when available.³² To do so, CMS should take steps to create a new field for clinical staff who have their own identification number to report this information. CMS should work with the designated standards development organization (X12) and the National Uniform Claim Committee to initiate this change on the claim form. Taking these steps would allow CMS to require providers to complete this field with the clinical staff’s identification number for both Medicare fee-for-service claims and Medicare Advantage encounters.

By taking these steps to increase transparency, CMS can strengthen program integrity efforts and enable oversight agencies to conduct more detailed analyses at the provider level. This information can also be used to help monitor quality of care and beneficiary safety related to the use of remote supervision.³³

Identify telehealth companies that bill Medicare

Some of the providers we identified who pose a high risk appear to be associated with telehealth companies. However, there is currently no systematic way to identify these companies in the Medicare data. To improve oversight of telehealth services, it is important that CMS and other oversight agencies be able to identify providers associated with telehealth companies on claims and encounters. CMS and others could use this information to more closely monitor these companies and identify companies that pose a risk to the Medicare program.

CMS should identify telehealth companies that bill Medicare. To do this, CMS could update the Medicare provider enrollment application (e.g., CMS-855B) to identify telehealth companies that enroll in Medicare. Alternatively, CMS could work with the National Uniform Claim Committee to add a taxonomy code that identifies telehealth companies. This information would allow CMS to monitor when beneficiaries receive services from providers associated with telehealth companies and could assist quality of care assessments in the future. The Medicare Payment Advisory Commission has noted concerns that if beneficiaries receive services via telehealth companies from clinicians who are not their usual source of care, their care may become fragmented.³⁴ It has also noted the need to identify telehealth companies to assess appropriate reimbursement for services provided by telehealth companies.³⁵

Follow up on the providers identified in this report

In a separate memorandum, we will refer to CMS the providers we identified as posing a high risk to Medicare. CMS should review this information and take action, as appropriate.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with our recommendation to follow up on the providers identified in this report, but CMS did not explicitly indicate whether it concurred with the other four recommendations.

CMS did not explicitly indicate whether it concurred with our recommendation to strengthen monitoring and targeted oversight of telehealth services. CMS stated that it will need to carefully review the issues identified to assess whether these issues have already been addressed, and if not, whether additional CMS actions are needed. In response, OIG emphasizes that this report highlights several ways that providers may be inappropriately billing for telehealth services and sheds light on potential methods specific to telehealth for safeguarding the program and protecting beneficiaries. Accordingly, we encourage CMS to strengthen targeted oversight of telehealth services to protect the Medicare program and beneficiaries against fraud, waste, and abuse. While OIG recognizes that the providers identified in this report represent a small percentage of the overall number of Medicare providers who billed for a telehealth service during the first year of the pandemic, that also means that targeted oversight of specific providers may be especially effective in addressing potential fraud, waste, and abuse related to telehealth services. Additionally, because this data brief focuses on specific measures with very high thresholds, it does not capture all concerning billing related to telehealth services that may be occurring in Medicare. Strengthening monitoring and targeted oversight could help prevent the number of high-risk providers from increasing in the future.

CMS also did not explicitly indicate whether it concurred with our recommendation to provide additional education to providers on appropriate billing for telehealth services. CMS noted that it has provided a variety of educational materials to promote proper billing for telehealth services and that it provides one-on-one education when appropriate and cost effective. CMS stated that it will analyze OIG's data to determine whether additional education is necessary. In response, OIG emphasizes that providing additional education to providers on how to correctly bill for telehealth services is one way to reduce inappropriate billing. We appreciate that CMS has taken some steps toward this recommendation and encourage it to further build on those steps. For example, while CMS has provided information on the location requirements for originating sites in a Medicare Learning Network Fact Sheet on telehealth services, providing additional education on when providers may or may not bill for the originating site facility fee can help reduce improper billing and payments.³⁶ We further note that many providers billed for telehealth services inappropriately but did not exceed the high thresholds we set for these measures.

CMS also did not explicitly indicate whether it concurred with our recommendation to improve the transparency of "incident to" services when clinical staff primarily delivered a telehealth service. CMS acknowledged that increasing transparency of

“incident to” services could aid in program integrity efforts. However, CMS stated that modifying the claim form to add a new field is not within the Agency’s control and requires extensive system changes that may impact the entire health care system. CMS further stated that it does not believe that a modifier is sufficient to address OIG’s concerns without a change to the claim form to identify the individual who primarily delivered the service. In response, OIG continues to emphasize the importance of CMS and oversight agencies having the ability to determine which provider rendered a telehealth service to a beneficiary. Accordingly, while OIG recognizes that modifying the claim form will take time and poses a significant undertaking, the need for increased transparency is important. As a critical partner with multiple representatives on the National Uniform Claim Committee, we encourage CMS to pursue the steps listed in this report to modify the claim form. In the meantime, OIG encourages CMS to use its authority to create a service code modifier to identify “incident to” services when clinical staff primarily delivered the service billed under a supervising practitioner’s identification number.

CMS also did not explicitly indicate whether it concurred with our recommendation to identify telehealth companies that bill Medicare. CMS stated that it has developed ways to assist with identifying telehealth companies and providers associated with telehealth companies. CMS noted that if it finds additional information is necessary it will evaluate the feasibility and benefits of modifying the provider enrollment application and/or adding a taxonomy code to identify telehealth companies. In response, OIG emphasizes that the findings of this report highlight the importance of CMS and other oversight agencies being able to identify providers associated with telehealth companies on claims and encounters to improve oversight of telehealth services.

CMS concurred with our recommendation to follow up on the providers identified in this report. CMS stated that it will review the providers identified as posing a high risk to Medicare and will follow up as appropriate.

We ask that CMS—in its Final Management Decision—provide details on any plans and progress toward implementing our recommendations.

For the full text of CMS’s comments, see Appendix C.

METHODOLOGY

We based this data brief on an analysis of Medicare fee-for-service claims data and Medicare Advantage encounter data. We included Medicare claims from Medicare fee-for-service and encounters from Medicare Advantage plans from March 1, 2020, to February 28, 2021. These data are similar to the data used in other reports in the series about Medicare beneficiaries' use of telehealth during the pandemic.³⁷

We used the Medicare Part B fee-for-service claims from the National Claims History File and Medicare Advantage encounters from Part C Encounter data. We included telehealth services billed by individual practitioners; we did not include telehealth services billed by institutional entities, such as hospitals and nursing homes. We included claims and encounters that were "final action" and approved for payment. We used provider enrollment data from the National Plan and Provider Enumeration System.³⁸

Analysis of Providers Who Billed for Telehealth Services

To conduct this analysis, we first identified the services that Medicare approved for telehealth during the pandemic.³⁹ These services can be provided via telehealth or in person. These services are identified using Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes. These codes are included on the claim by a provider for reimbursement purposes.

Our analysis included virtual care services as a type of telehealth service. These services are also referred to as communication technology-based services. These services are always provided remotely, and include virtual check-ins, e-visits, remote monitoring, and telephone calls with a provider to discuss a beneficiary's medical condition.

We identified other services that were provided via telehealth using a modifier (i.e., 95, GT, GQ, or G0) or a place of service code (i.e., 02) that indicates the service was delivered via telehealth.⁴⁰

Next, we identified providers who billed Medicare for telehealth services. These are the providers identified on the claims and encounter data as rendering the service. We included individual providers such as physicians and non-physician practitioners who billed either Medicare fee-for-service, Medicare Advantage plans, or both.⁴¹

Program Integrity Measures

To identify providers who pose a high risk to Medicare, we developed seven measures as indicators of possible fraud, waste, or abuse. These measures focus on different types of billing for telehealth that providers may use to maximize their Medicare

payments. We developed these measures based on analyses of Medicare data and input from OIG investigators.

In total, we identified 741,759 providers who billed for a telehealth service during the pandemic. For each provider, we analyzed the telehealth services they billed to Medicare. For each measure, we developed thresholds that may indicate possible fraud, waste, or abuse. All of the thresholds reflect extreme levels—they are all higher than thresholds based on a standard technique to identify outliers, known as the Tukey method.⁴²

For each provider, we calculated the following measures:

1. Billing for both a telehealth service and a facility fee for the majority of visits

For each provider, we determined the percentage of visits that included both an originating site facility fee and a telehealth service.⁴³ We identified providers who billed both an originating site facility fee and a telehealth service for more than 75 percent of their visits; most providers never billed this way.

2. Billing telehealth services at the highest, most expensive level every time

For each provider, we calculated the percentage of telehealth services billed at the highest level for the following services: (1) office visits, (2) nursing home visits, (3) assisted living visits, and (4) home visits.⁴⁴ We identified providers who always billed for telehealth services at the highest level for each of these types of services; most providers rarely, if ever, billed at the highest level.

We also determined the percentage of services that were prolonged (i.e., a duration of time spent beyond the maximum time for the highest level of service).

3. Billing telehealth services for a high number of days

For each provider, we determined the total number of days worked during the 1-year timeframe of our analysis. We identified providers who billed telehealth services for more than 300 days—far higher than the median of 26 days. Billing for more than 300 days in a year averages to more than 25 days a month for each provider.

4. Billing both Medicare fee-for-service and a Medicare Advantage plan for the same service for a high proportion of services

For each provider, we calculated the percentage of services that were billed to both Medicare fee-for-service and a Medicare Advantage plan for the same telehealth service for the same beneficiary on the same date of service.⁴⁵ We identified providers who billed both Medicare fee-for-service and a Medicare Advantage plan for the same service for more than 20 percent of their services; most providers never billed this way.

5. Billing a high average number of hours of telehealth services per visit

For each provider, we calculated the average number of hours of telehealth service provided per visit.⁴⁶ We identified providers who billed more than an average of 2 hours per visit—far higher than the median of 21 minutes.

6. Billing telehealth services for a high number of beneficiaries

For each provider, we calculated the number of beneficiaries for whom they had billed a telehealth service. We identified providers who billed telehealth services for 2,000 or more beneficiaries—far higher than the median of 21 beneficiaries.⁴⁷

7. Billing for a telehealth service and ordering medical equipment for many of their beneficiaries

For each provider, we calculated the percentage of beneficiaries for whom they had billed a telehealth service and then ordered medical equipment and supplies.⁴⁸ We focused this analysis on durable medical equipment and components, accessories, and supplies; orthotics and services; and prosthetics that were billed within 3 months of the telehealth service. We identified providers who billed for a telehealth service and ordered medical equipment and supplies for at least half of their beneficiaries—far higher than the median of 3 percent of beneficiaries.

Additionally, for each provider, we focused on the beneficiaries for whom they had ordered medical equipment and supplies and calculated the percentage of these beneficiaries for whom the provider did not have an established relationship. To determine whether a beneficiary had an established relationship with a provider, we identified the date of the first telehealth service with the provider and looked back to January 2018 to determine whether the beneficiary had a prior in-person visit or other service with that same provider (i.e., providers in the same medical practice).

In addition, for each provider, we focused on the beneficiaries for whom they had ordered medical equipment and supplies and calculated the percentage of these beneficiaries' services that were provided audio-only.⁴⁹

Analysis of Providers Whose Billing Poses a High Risk

We identified the providers who exceeded the threshold on at least one of seven measures. These are providers whose billing is concerning and poses a high risk to Medicare.

As a next step, we determined whether the providers we identified based on the measures described above had certain characteristics in common. We looked at the most common services billed and instances where providers are a part of the same medical practice.⁵⁰

In addition, we identified providers who appear to be associated with telehealth companies by reviewing the name of the provider billing Medicare. However, there is currently no systematic way to identify these companies in the Medicare data.

Limitations

We designed this study to identify telehealth providers who warrant further scrutiny. None of the measures that we analyzed confirm that a particular provider is engaging in fraudulent or abusive practices. Any determination of fraud or an overpayment would require additional investigation. Further, because we could not identify “incident to” billing, we were unable to include certain measures that could have captured additional fraud, waste, and abuse that may be occurring. For example, we could not identify providers who were billing for more than 24 hours in a day.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

APPENDIX A

Examples of Medicare Telehealth Services



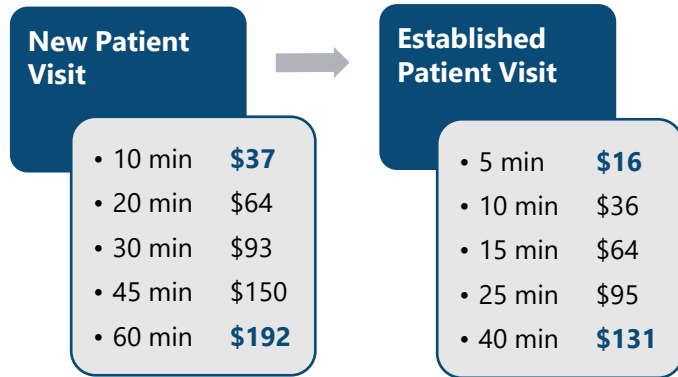
APPENDIX B

Billing for Various Levels of Complexity and Duration

Office Visits

Office visits represented 48 percent of all services provided via telehealth during the pandemic.⁵¹ These visits include services with primary care providers and specialists for the purpose of evaluating or managing

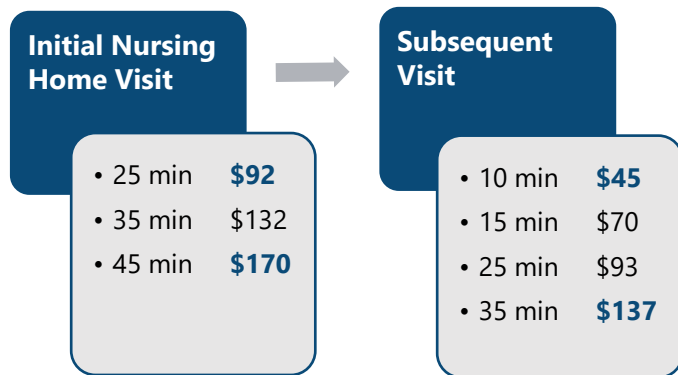
the beneficiary's medical condition. The payment amount for the highest complexity level for new patients is five times the amount for the lowest complexity level. For established patients, it is almost eight times the amount.



Nursing Home Visits

In the first 30 days after a beneficiary's admission, Medicare requires a physician to conduct an initial visit to assess the beneficiary's condition, develop a plan of care, and write or verify their admitting orders.⁵²

Medicare also requires periodic physician visits to monitor and evaluate nursing facility residents during their stay.⁵³ In addition, Medicare will cover physician visits outside of the periodic checks that are deemed medically necessary.⁵⁴



Initial nursing facility visits can range in duration from 25 to 45 minutes. Subsequent nursing facility visits can range in duration from 10 to 35 minutes. The payment amount for the highest complexity level for initial visits is nearly double the amount for the lowest complexity level. For subsequent visits, it is about three times the amount.

Assisted Living Visits

Medicare covers visits by providers to oversee or directly provide beneficiaries with examinations and medical counseling in an assisted living setting.⁵⁵ These visits must be medically necessary and an extension of normal beneficiary care.⁵⁶ Assisted living visits for new patients

New Patient Visit		Established Patient Visit	
• 20 min	\$56	• 15 min	\$61
• 30 min	\$81	• 25 min	\$97
• 45 min	\$141	• 40 min	\$137
• 60 min	\$190	• 60 min	\$198
• 75 min	\$224		

can range in duration from 20 to 75 minutes. Assisted living visits for established patients can range in duration from 15 to 60 minutes. The payment amount for the highest complexity level for a new patient assisted living visit is four times the amount for the lowest complexity level. For established patients it is three times the amount.

Home Visits

A home visit is an evaluation and management service provided by a physician to a beneficiary in their private residence. Unlike with home health services, the beneficiary does not need to be confined to their home to receive a home visit. Home visits for new patients can range in duration from 20 to 75

New Patient Visit		Established Patient Visit	
• 20 min	\$56	• 15 min	\$56
• 30 min	\$80	• 25 min	\$86
• 45 min	\$131	• 40 min	\$131
• 60 min	\$186	• 60 min	\$183
• 75 min	\$226		

minutes. Home visits for established patients can range in duration from 15 to 60 minutes. The payment amount for the highest complexity level for new patients is four times the amount for the lowest complexity level. For established patients, it is about three times the amount.

*Administrator*

Washington, DC 20201

DATE: July 29, 2022

TO: Gregory E. Demske
Acting Principal Deputy Inspector General
Office of Inspector General

FROM: Chiquita Brooks-LaSure *Chiq B LaS*
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Data Brief: Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks (OEI-02-20-00720)

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 serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes. Consistent with these goals, CMS issued waivers to prevent gaps in access to care for patients affected by the COVID-19 public health emergency (PHE), including waivers for services furnished via telehealth. The changes to payment and coverage policies were intended to allow health care providers maximum flexibility to minimize the spread of COVID-19 among Medicare beneficiaries, health care personnel, and the community at large and increase capacity to address the needs of their patients.

On March 17, 2020, CMS announced the expansion of telehealth services on a temporary and emergency basis pursuant to waiver authority added under section 1135(b)(8) of the Social Security Act by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. 116-123, March 6, 2020). Beginning on March 6, 2020, and for the duration of the COVID-19 PHE, Medicare pays for telehealth services, including office, hospital, and other visits furnished by physicians and other practitioners to patients located anywhere in the country, including in a patient's place of residence. In the context of the COVID-19 PHE, CMS recognized that the use of telehealth could help address new challenges regarding potential exposure risks, for people with Medicare, health care providers, the community at large. To facilitate the use of telecommunications technology as a safe substitute for in-person services, CMS, on a temporary interim final basis, added many services to the list of eligible Medicare telehealth services, eliminated frequency limitations and other requirements associated with particular services furnished via telehealth, and clarified several payment rules that apply to other

services that are furnished using telecommunications technologies that can reduce exposure risks.¹

CMS recognizes the importance of analyzing the impact of these changes, and, as such, immediately evaluated the waivers and flexibilities issued by the Agency to determine the potential for fraud, waste, and abuse in the Medicare program. This process included identifying program integrity risks and vulnerabilities associated with the waivers and flexibilities; prioritizing those with the largest potential for financial loss, beneficiary harm and/or likelihood of occurrence; and creating mitigations that addressed these program integrity risks and vulnerabilities, including those related to telehealth.

One such mitigation strategy has been the continued use of data analytics to identify potential program integrity risks. CMS has continued throughout the PHE to analyze claims data to monitor, trend, and respond to existing telehealth fraud schemes and to detect and respond to potential new emerging fraud schemes. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, which includes the use of the Fraud Prevention System (FPS). The FPS is a predictive analytics technology that runs sophisticated algorithms against Medicare Fee-For-Service (FFS) claims nationwide. When FPS models identify aberrant activity or patterns, the system automatically generates and prioritizes leads for further review and investigation by Unified Program Integrity Contractors (UPICs). Based on the results of all information collected, the UPICs coordinate with CMS and the Medicare Administrative Contractors in taking appropriate administrative action to recover improper payments and prevent future loss of funds, or the UPICs refer the case to law enforcement.

Additionally, CMS has supported our federal law enforcement partners throughout the PHE on various fraud schemes including those related to telehealth. CMS continues to meet regularly with law enforcement to discuss new cases, fraud referrals, active UPIC and law enforcement cases, and paths for various administrative actions.

CMS has also taken action to prevent improper Medicare payments by educating health care providers and suppliers on proper billing. For example, CMS has undertaken a number of stakeholder calls including open door forums and Medicare Learning Network calls, as well as published numerous pieces of subregulatory guidance designed to educate practitioners on the additional telehealth flexibilities, including how to appropriately bill for these services.²

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

OIG Recommendation

The OIG recommends that CMS strengthen monitoring and targeted oversight of telehealth services.

¹ The list of these eligible telehealth services is published on the CMS website at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>.

² Open Door Forum Podcast and Transcripts available at: <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts>; COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service (FFS) Billing available at: <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>; Physician Fee Schedule Proposed Rule: Understanding 4 Key Topics Listening Session, August, 13, 2020. Available at: <https://www.cms.gov/outreach-and-education/outreachnpcnational-provider-calls-and-events/2020-08-13>; CMS.gov Current Emergencies webpage available at: <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>

CMS Response

The providers identified by the OIG and their total associated Medicare FFS payments represent a small portion of the services furnished via telehealth during the first year of the PHE—representing approximately two tenths of a percent of all providers who billed for telehealth and approximately 2.5 percent of all Medicare FFS payments for telehealth services. While these are relatively small percentages, CMS takes these findings seriously and appreciates the OIG’s review in this area. Given that this report was conducted outside of CMS’s and law enforcement entities’ program integrity efforts, CMS will need to carefully review the issues identified to assess whether these issues have already been addressed, and if not, whether additional CMS actions are needed. CMS looks forward to receiving details on these issues.

CMS will review the providers identified as posing a high risk to Medicare against those telehealth providers already identified by CMS and within the context of the larger program integrity strategy, and determine whether any additional monitoring or oversight of telehealth services is necessary.

OIG Recommendation

The OIG recommends that CMS provide additional education to providers on appropriate billing for telehealth services.

CMS Response

As stated above, CMS has provided a variety of educational materials to promote proper billing for telehealth services. OIG specifically states that CMS should include information such as when it is appropriate to bill an originating site facility fee and how to avoid billing Medicare FFS and a Medicare Advantage plan for the same service. CMS has provided information on the requirements for originating sites as well as how to check Medicare eligibility which shows whether a beneficiary is enrolled in a Medicare Advantage plan, to facilitate proper submission of claims.^{3,4} OIG also suggests that CMS should target specific providers with high levels of inappropriate billing for telehealth services and provide one-on-one education to them. CMS provides one-on-one education when appropriate and cost effective. CMS will analyze OIG’s data and determine whether additional education, including one-on-one education, is necessary.

OIG Recommendation

The OIG recommends that CMS improve the transparency of “incident to” services when clinical staff primarily delivered a telehealth service.

CMS Response

CMS acknowledges that increasing transparency of “incident to” services could aid in program integrity efforts; however, modifying the claim form to add a new field is not within the Agency’s control. As mentioned in the full recommendation in the report, modification of the claim form is a function of the designated standards maintenance organization. Modifications to the claim form are a significant undertaking and require extensive system changes that impact the entire healthcare system. Therefore, this process requires industry consensus and is not based strictly on Medicare need or preference.

³ Medicare Learning Network (MLN) Fact Sheet: Telehealth Services (June 2021) available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf>

⁴ MLN Fact Sheet: Checking Medicare Eligibility (October 2021) available at: <https://www.cms.gov/files/document/checking-medicare-eligibility.pdf>

OIG also suggests that CMS require a modifier to indicate “incident to” telehealth services. CMS does not believe that a modifier is sufficient to address the OIG’s concerns without the change to the claim form to identify the individual who primarily delivered the service.

OIG Recommendation

The OIG recommends that CMS identify telehealth companies that bill for Medicare.

CMS Response

Based on the OIG’s findings, the risk associated with telehealth companies is unclear. As stated above, CMS has a robust program integrity strategy. As part of this strategy, CMS has developed ways to assist with identifying telehealth companies and providers associated with telehealth companies. Consistent with Recommendation 5 below, CMS will review the providers identified as posing a high risk to Medicare against those telehealth providers already identified by CMS, and within the context of the larger program integrity strategy, and determine whether additional information is necessary to identify telehealth companies. If additional information is necessary, CMS will evaluate the feasibility and benefits of modifying the provider enrollment application and/or adding a taxonomy code to identify telehealth companies.

OIG Recommendation

The OIG recommends that CMS follow up on the providers identified in the report.

CMS Response

CMS concurs with this recommendation. CMS will review the providers identified as posing a high risk to Medicare against those telehealth providers already identified by CMS, and within the context of the larger program integrity strategy. If necessary, CMS will follow up as determined appropriate.

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Judy Kellis served as the team leader for this study. Others in the Office of Evaluation and Inspections who conducted the study include Alexis Mills and John Gordon. Office of Evaluation and Inspections staff who contributed to the study include Miriam Anderson, Robert Gibbons, Eddie Baker, Jr., and Michael Novello.

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

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ENDNOTES

¹ HHS and CMS were able to temporarily expand access to telehealth because of their waiver authority under section 1135 of the Social Security Act, subsequent legislation, and the Secretary's declaration of a public health emergency due to COVID-19. The public health emergency was announced on January 31, 2020. See HHS, *Determination that a Public Health Emergency Exists*, January 31, 2020, accessed at <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx> on April 8, 2022. See also Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020, accessed at <https://www.congress.gov/bill/116th-congress/house-bill/6074/text/rds> on November 23, 2021. See also Families First Coronavirus Response Act, accessed at <https://www.congress.gov/bill/116th-congress/house-bill/6201/text> on April 15, 2022. See also CARES Act, accessed at <https://www.congress.gov/bill/116th-congress/house-bill/748/text> on November 23, 2021.

² CMS, *Coronavirus Disease 2019 (COVID-19) Provider Burden Relief Frequently Asked Questions (FAQs)*, July 2020. Accessed at <https://www.cms.gov/files/document/provider-burden-relief-faqs.pdf#:~:text=On%20March%2030%20CMS%20suspended%20most%20Medicare%20Fee-For-Service,potentially%20selected%20for%20review%20will%20also%20be%20applied> on December 28, 2021.

³ OIG, *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*, OEI-02-20-00520, March 2022.

⁴ OIG, *Most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship*, OEI-02-20-00521, October 2021; OIG, *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*, OEI-02-20-00520, March 2022; OIG, *Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic*, OEI-02-20-00522, September 2022; Pandemic Response Accountability Committee, *Telehealth Services in Select Federal Health Care Programs*, forthcoming.

⁵ For the purposes of this report, we refer to the services that can be delivered either via telehealth or in-person—as well as services that are always provided remotely—as telehealth services.

⁶ These services are also referred to as communication technology-based services. For the purposes of this report, we refer to them as virtual care services. CMS does not include communication technology-based services in its formal definition of telehealth services.

⁷ For example, prior to the pandemic, beneficiaries were allowed to use telehealth services to address substance use disorder or end-stage renal disease from their home and in urban areas. In addition, beginning in 2020, beneficiaries enrolled in Medicare Advantage plans were allowed to use telehealth services in their home and in urban areas.

⁸ For the purposes of this study, we included telehealth services that Medicare had approved for payment as of February 28, 2021.

⁹ Prior to the pandemic, beneficiaries could receive certain services, such as virtual check-ins, through audio-only.

¹⁰ For more information, see DOJ, "Federal Law Enforcement Action Involving Fraudulent Genetic Testing Results in Charges Against 35 Individuals Responsible for Over \$2.1 Billion in Losses in One of the Largest Health Care Fraud Schemes Ever Charged," September 27, 2019; see also DOJ, "National Health Care Fraud and Opioid Takedown Results in Charges Against 345 Defendants Responsible for More Than \$6 Billion in Alleged Fraud Losses," September 30, 2020; see also DOJ, "DOJ Announces Coordinated Law Enforcement Action To Combat Health Care Fraud Related to COVID-19," May 26, 2021; see also DOJ, "Nationwide Coordinated Law Enforcement Action to Combat Telemedicine, Clinical Laboratory, and Durable Medical Equipment Fraud," July 20, 2022.

¹¹ The analysis includes billing by individual practitioners but not by institutions, such as hospitals.

¹² If these services were provided as billed, it raises concerns about the quality of services. For example, providers who billed for a high number of days or a high number of beneficiaries may not be providing proper supervision or spending an adequate amount of time with each beneficiary.

¹³ This amount includes Medicare payments, beneficiary copays and deductible amounts, and any third-party payments for services billed to Medicare-fee-for-service.

¹⁴ For the purposes of this report, we refer to the organization that billed Medicare for the telehealth service as the medical practice.

¹⁵ These companies are also referred to as direct-to-consumer telehealth vendors. A provider may be associated with more than one telehealth company. For more information on telehealth companies, see University of Michigan Institute for Healthcare Policy and Innovation, *Telehealth Research Incubator's Research Snapshots*, July 2021. Accessed at https://ihpi.umich.edu/sites/default/files/2021-08/Telehealth_Research_Snapshots_Databook_2021.pdf on January 7, 2022.

¹⁶ Only the physician or practitioner may receive payment for the telehealth service, and only the facility may bill for the facility fee. The physician or practitioner who provides the telehealth service may not bill or receive payment for the facility fee. See 42 CFR §§ 414.65(a)(1) and (b)(2).

¹⁷ See CMS, COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, p. 62. Accessed at <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>, on December 28, 2021.

¹⁸ We focused our analysis on certain types of services that providers can bill for at different levels depending on their complexity or duration; these services include office visits, nursing home visits, assisted living visits, and home visits.

¹⁹ To bill for an office visit that was prolonged, providers bill one or more procedure codes that indicate the extra number of minutes that the service was prolonged. These procedure codes have specific payment amounts associated with them.

²⁰ Five of these providers always billed for the highest level for two types of visits, such as assisted living visits and home visits.

²¹ A total of 18,034 providers billed both Medicare fee-for-service and Medicare Advantage for the same telehealth service for the same beneficiary on the same date of service at least once. Although each of these providers billed this way at least once, we did not consider them high risk unless they billed this way for more than 20 percent of their claims and encounters.

²² We analyzed hours per visit to avoid the problem of "incident to" billing. Regardless of whether the practitioner or clinical staff are providing services "incident to" the practitioner, it is concerning that they are consistently billing for telehealth visits that last longer than 2 hours—especially in relation to the median length of 21 minutes per visit.

²³ CMS, *Medicare Fraud & Abuse: Prevent, Detect, Report*, January 2021. Accessed at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf> on April 22, 2021.

²⁴ We focused this analysis on providers who ordered medical equipment and supplies billed to Medicare fee-for-service. Medicare Advantage plans are not required to report information about the ordering provider to Medicare.

²⁵ 85 Fed. Reg. 19230 (Apr. 6, 2020).

²⁶ In these cases, the providers billed for the telehealth services. For more information on the differences between telehealth fraud and telefraud, see OIG, "Principal Deputy Inspector General Grimm on Telehealth," February 26, 2021. Accessed at <https://oig.hhs.gov/coronavirus/letter-grimm-02262021.asp> on February 10, 2022.

²⁷ These schemes also involved genetic testing laboratories, and pharmacies. See DOJ, "National Health Care Fraud Enforcement Action Results in Charges Involving Over \$1.4 Billion in Alleged Losses," September 17, 2021; see also DOJ, "Nationwide Coordinated Law Enforcement Action to Combat Telemedicine, Clinical Laboratory, and Durable Medical Equipment Fraud," July 20, 2022.

- ²⁸ For more information on CMS’s Fraud Prevention System and Healthcare Fraud Prevention Partnership, see <https://www.cms.gov/About-CMS/Components/CPI/CPI-Investing-In-Data-and-Analytics>.
- ²⁹ OIG has additional evaluations and audits underway examining telehealth in Medicare to help further inform program policies and oversight. See the HHS-OIG Work Plan, which can be found at <https://oig.hhs.gov/reports-and-publications/workplan/index.asp>.
- ³⁰ These reports are limited to Medicare fee-for-service claims. Further information on the Comparative Billing Reports that CMS sends to providers can be found at <https://cbr.cbrpepper.org/home>.
- ³¹ OIG, *Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services*, OEI-09-06-00430, August 2009.
- ³² There may be clinical staff without an individual identification number billing “incident to” a supervising practitioner. In these instances, we would not expect providers to report the clinical staff’s identification number.
- ³³ The Medicare Payment Advisory Commission has noted that there are quality of care and beneficiary safety concerns related to the use of remote supervision when the supervising practitioner is not physically available to help if necessary. See 86 Fed. Reg. 64996 (Nov. 19, 2021).
- ³⁴ Medicare Payment Advisory Commission, *Report to Congress March 2021, Chapter 14: Telehealth in Medicare after the coronavirus public health emergency*. Accessed at https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch14_sec.pdf on January 4, 2022.
- ³⁵ Telehealth companies may have lower costs than providers who see beneficiaries in person. See Medicare Payment Advisory Commission, *Report to Congress March 2021, Chapter 14: Telehealth in Medicare after the coronavirus public health emergency*. Accessed at https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch14_sec.pdf on January 4, 2022.
- ³⁶ CMS, *Telehealth Services*, June 2021. Accessed at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcfsctst.pdf> on August 11, 2022.
- ³⁷ OIG, *Most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship*, OEI-02-20-00521, October 2021; OIG, *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*, OEI-02-20-00520, March 2022; OIG, *Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic*, OEI-02-20-00522, September 2022.
- ³⁸ We also supplemented this information with data from other sources, such as CMS contractor data and the Medicare Provider Enrollment, Chain, and Ownership System.
- ³⁹ The codes used in the analysis include those on the list available on the CMS website as of February 28, 2021, which can be found at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>. These codes also include the communication technology-based services—referred to in this report as virtual care services—that were allowed during the first year of the pandemic. See 85 Fed. Reg. 19230 (Apr. 6, 2020) and 84472 (Dec. 28, 2020).
- ⁴⁰ We included all virtual care services as being provided via telehealth as they can only be provided remotely.
- ⁴¹ We included professional services billed to Medicare fee-for-service and Medicare Advantage. We did not include telehealth services provided directly by institutional entities, such as hospitals and nursing homes.
- ⁴² The Tukey method identifies outliers that are above the 75th percentile plus three times the interquartile range.
- ⁴³ This analysis included providers who billed 10 or more visits. Further, this analysis includes only individual providers that billed for both a facility fee and a telehealth service. In some instances, an institutional provider, such as a hospital outpatient department, is able to bill for both the facility fee and a telehealth service for the same visit. Such providers were not included

in this analysis. For more detail, see CMS, *COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing*. Accessed at <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf> on December 28, 2021.

⁴⁴ Some procedures may be billed with more than one service unit in the same visit. For the purposes of this report, we considered one service unit to be one service. In addition, this analysis included providers who billed 50 or more services.

⁴⁵ This analysis included providers who billed 50 or more services.

⁴⁶ This analysis included providers with 25 or more telehealth visits. It did not include services that take more than 100 minutes and psychological testing and evaluation procedures. To calculate the average number of hours of services for each visit, we used the median number of minutes for each service provided by CMS. For more information on CMS's calculation of the median number of minutes per service, see <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeeschedpfs-federal-regulation-notices/cms-1751-f>.

⁴⁷ When determining this threshold, we considered other research on provider caseload size. See J. Altschuler, D. Margolius, T. Bodenheimer, and K. Grumbach, "Estimating a reasonable patient panel size for primary care physicians with team-based task delegation." *Annals of Family Medicine*, Vol. 10, No. 5, 2012, p. 396.

⁴⁸ This analysis included providers with 50 or more beneficiaries.

⁴⁹ We focused on the six telehealth services that can be identified as being provided through audio-only. We did not include the other telehealth services that may be provided through audio-only because it cannot be distinguished whether they were provided as audio-only services or as audio-video services.

⁵⁰ We determined that providers worked for the same medical practice if they had the same billing National Provider Identifier on their claims and encounters.

⁵¹ OIG, *Most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship*, OEI-02-20-00521, October 2021.

⁵² CMS, *CMS Manual System: Nursing Facility Services (Codes 99304–99318)*, April 2008. Accessed at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1489CP.pdf> on March 19, 2021.

⁵³ CGS Administrators, *Fact Sheet: Subsequent Nursing Facility Care*, February 2019. Accessed at <https://www.cgsmedicare.com/partb/mr/pdf/99307.pdf> on March 19, 2021.

⁵⁴ *Ibid.*

⁵⁵ Noridian, *Home and Domiciliary Visits*, August 2019. Accessed at <https://med.noridianmedicare.com/web/jfb/specialties/em/home-and-domiciliary-visits> on March 19, 2021.

⁵⁶ *Ibid.*