

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE GENERALLY PAID FOR
EVALUATION AND MANAGEMENT SERVICES
PROVIDED VIA TELEHEALTH
DURING THE FIRST 9 MONTHS OF THE
COVID-19 PUBLIC HEALTH EMERGENCY
THAT MET MEDICARE REQUIREMENTS**

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Report in Brief

Date: February 2024

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



Why OIG Did This Audit

In response to the COVID-19 public health emergency (PHE), CMS temporarily expanded access to health services provided via telehealth. From March 2020 through November 2020 (audit period), Medicare Part B paid approximately \$10.3 billion for Evaluation and Management (E/M) services, including telehealth services, provided to Medicare enrollees nationwide. The telehealth expansion increased the risk of inappropriate payments in the Medicare program due to the extent and speed of the changes. Therefore, CMS's oversight of the telehealth expansion becomes increasingly important to ensure that enrollees receive the appropriate quality of care both during and after the PHE, while protecting the Medicare program from fraud, waste, and abuse.

Our objective was to determine whether physicians and other practitioners that provided E/M services via telehealth complied with Medicare requirements.

How OIG Did This Audit

Our audit covered \$1.4 billion in Medicare Part B payments for more than 19 million E/M claim line services that were billed with place of service codes or modifiers indicating telehealth was used to provide the service our audit period. We selected a stratified random sample containing three strata of E/M services provided via telehealth during the audit period. One stratum included 30 E/M services billed as telehealth services provided to new patients and the other two strata each included 40 E/M services billed as telehealth services provided to established patients.

Medicare Generally Paid for Evaluation and Management Services Provided via Telehealth During the First 9 Months of the COVID-19 Public Health Emergency That Met Medicare Requirements

What OIG Found

Physicians and other practitioners that provided E/M services via telehealth generally complied with Medicare requirements. For 105 of the 110 sampled E/M services provided via telehealth, providers complied with Medicare requirements. However, for the remaining five sampled E/M services, providers did not comply with Medicare requirements. Medicare paid \$446 for the five sampled E/M services for which providers did not document or insufficiently documented the services. We also identified potential documentation issues in the medical records used to support the sampled E/M services that we discuss in the Other Matters section of this report.

This report does not have recommendations because providers generally met Medicare requirements when billing for E/M services provided via telehealth and unallowable payments we identified resulted primarily from clerical errors or the inability to access records.

CMS elected not to provide comments on our draft report.

TABLE OF CONTENTS

| | |
|--|----|
| INTRODUCTION..... | 1 |
| Why We Did This Audit..... | 1 |
| Objective..... | 1 |
| Background..... | 2 |
| The Medicare Program | 2 |
| COVID-19 Public Health Emergency and Expansion of Access to Telehealth..... | 2 |
| The Medicare Physician Fee Schedule..... | 3 |
| Evaluation and Management Services..... | 3 |
| Billing Medicare for Evaluation and Management Services Provided via Telehealth..... | 4 |
| Documentation of Evaluation and Management Services | 5 |
| Prior Office of Inspector General Work | 7 |
| How We Conducted This Audit | 8 |
| FINDING..... | 8 |
| Providers Generally Met Medicare Requirements When Billing for Evaluation and Management Services Provided via Telehealth | 9 |
| CONCLUSION..... | 9 |
| OTHER MATTERS: POTENTIAL DOCUMENTATION ISSUES..... | 10 |
| Potential Documentation Issues Related to Evaluation and Management Services..... | 10 |
| Potential Documentation Issues Related to Telehealth | 11 |
| APPENDICES | |
| A: Audit Scope and Methodology | 14 |
| B: Evaluation and Management Current Procedural Terminology Codes and Descriptions | 16 |
| C: Related Office of Inspector General Reports..... | 17 |
| D: Statistical Sampling Methodology | 18 |
| E: Sample Results..... | 20 |

INTRODUCTION

WHY WE DID THIS AUDIT

The COVID-19 pandemic caused unprecedented challenges for providing and receiving in-person health care as well as significant health and safety concerns. In response to the COVID-19 public health emergency (PHE), in March 2020, Congress and the Secretary of Health and Human Services (HHS) authorized the Centers for Medicare & Medicaid Services (CMS) to temporarily implement waivers and modifications to Medicare program requirements. These changes expanded access during the PHE to health services provided via telehealth (using remote communications technologies) by temporarily eliminating or revising some of the requirements for these services.¹ The waivers and modifications provided more options for people enrolled in Medicare to receive services provided via telehealth, such as evaluation and management (E/M) services, in the face of the PHE's challenges.

Previously, Medicare could only pay for telehealth on a limited basis to support rural access to care services. As a part of the telehealth expansion, CMS covered additional services, additional distant and originating site locations, and video technology. This helped ensure that Medicare enrollees were able to receive services from their homes without having to visit an office or hospital, which could have put them and others at risk. This also allowed a wider range of providers to offer telehealth services to patients. The additional telehealth services included E/M services performed by physicians and other practitioners via interactive audio and video telecommunications systems or audio-only to assess and manage an enrollee's health.

We conducted this nationwide audit of E/M services because of the significant increase in E/M services billed as telehealth services during the PHE. During our audit period, from March 1, 2020, through November 30, 2020, Medicare Part B paid approximately \$10.3 billion for E/M services, including \$1.4 billion in services provided via telehealth, for Medicare enrollees nationwide. Our analysis determined that 14 percent of the total amount that Medicare paid for E/M services provided during our audit period was for telehealth services (compared with less than 0.1 percent from March 1, 2019, through November 30, 2019).

OBJECTIVE

Our objective was to determine whether physicians and other practitioners that provided E/M services via telehealth complied with Medicare requirements.

¹ The PHE ended May 11, 2023. In response to the Consolidated Appropriations Act, 2023, CMS has already made some of these temporary waivers and modifications permanent and has extended flexibilities for Medicare coverage of payment for telehealth services through Dec. 31, 2024.

BACKGROUND

The Medicare Program

The Medicare program, established by Title XVIII of the Social Security Act (the Act), provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the Medicare program. Medicare Part B provides supplementary medical insurance for medical and other health services, such as outpatient services, which include E/M services.

COVID-19 Public Health Emergency and Expansion of Access to Telehealth

The PHE created unprecedented challenges in Medicare enrollees' access to health care services. In response to the PHE, HHS and CMS took a number of actions to temporarily expand access to telehealth for Medicare enrollees.² Telehealth (also known as telemedicine) uses electronic information and telecommunications technologies to provide care when a health care provider and enrollee are not in the same physical location. CMS expanded access, allowing enrollees to use telehealth for a wide range of services and in a wider array of locations, including urban areas.³

CMS allowed providers to deliver services via telehealth through live-video or audio-only visits.⁴ In addition, HHS issued a temporary notice to allow providers during the PHE to use any nonpublic-facing remote communication product that is available to communicate with patients.⁵ Although providers could choose to use video communication products that are

² HHS and CMS were able to temporarily expand access to telehealth because the declaration of the PHE and national emergency allowed the HHS Secretary to use the waiver authority under section 1135 of the Act. On Mar. 13, 2020, President Trump declared the COVID-19 outbreak a national emergency. The Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 and the Coronavirus Aid, Relief, and Economic Security Act broadened the waiver authority under section 1135 of the Act which allowed HHS and CMS to waive additional telehealth-related restrictions with a PHE declaration in place.

³ Prior to the PHE, Medicare could only pay for telehealth on a limited basis to support rural access to care services. These telehealth services were required to be provided through live, interactive audio-video conferencing between an enrollee located at a certified rural originating site (clinic, hospital, or certain other types of medical facilities for the service; not an enrollee's home or office) and a practitioner located at a distant site. See CMS's "[Medicare Telemedicine Health Care Provider Fact Sheet](#)." Accessed on Apr. 11, 2023.

⁴ A live-video visit, also referred to as a "real-time" visit, is two-way, face-to-face interaction between a patient and provider using audiovisual communications technology. An audio-only visit is the use of a telephone without video.

⁵ Under this notification, HHS would not impose penalties against covered health care providers for noncompliance with the HIPAA Rules that relates to the good faith provision of telehealth services during the COVID-19 nationwide public health emergency (85 Fed. Reg. 22024 (Apr. 21, 2020)). HHS, "[Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency](#)." Accessed on Apr. 11, 2023.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant and provide additional privacy protections, they were not required to do so during the PHE.

The Medicare Physician Fee Schedule

Under Medicare Part B, Healthcare Common Procedure Coding System (HCPCS) codes,^{6, 7} Current Procedural Terminology (CPT) codes,⁸ modifiers, and their descriptions are used for the purpose of reporting physicians' services. Reimbursement rates for physician's services are based primarily on CMS's Medicare Physician Fee Schedule and the rates for each respective procedure code vary depending on the relative value and geographic location of the service.⁹ Additional rate adjustments may be made based upon payment modifiers.

Evaluation and Management Services

E/M services are visits covered under Medicare Part B and performed by physicians and nonphysician practitioners (hereinafter, collectively referred to as providers) to assess and manage an enrollee's health.¹⁰ E/M services are divided into broad categories that reflect the type of service, the place of service, and the patient's status (i.e., new or established patient).

The *Medicare Claims Processing Manual* (the Manual) states that documentation should support the level of service reported (Pub. No. 100-04, chapter 12, § 30.6.1 (A)).¹¹ In addition, the Act § 1833(e) states that no payment shall be made to any provider of services or other

⁶ HCPCS codes are 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.

⁷ HCPCS codes are divided into two primary groups: level I and level II. Level I HCPCS codes consist of five-character all numeric CPT codes that are maintained by the American Medical Association (AMA) and used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II HCPCS codes consist of five-character alpha-numeric codes that are primarily used to report items and nonphysicians' services not included in the CPT codes. Our audit relates to the Level I HCPCS/CPT codes for E/M services, which we refer to as "procedure codes" for reporting purposes.

⁸ **The five-character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2019–2020 by the AMA. CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

⁹ The Act § 1848(a)(1) establishes that Medicare Part B payments for physicians' services shall be made based on the lesser of the actual charge or the applicable fee schedule amount for the services.

¹⁰ Nonphysician practitioners are health care providers (e.g., nurse practitioners, clinical nurse specialists, and physician assistants) who practice either in collaboration with a physician or under the supervision of a physician.

¹¹ Rev. 11842 moved this statement to § 30.6.1(B) effective Jan. 1, 2023.

person unless there has been furnished such information as may be necessary to determine the amounts due such provider.

Providers bill Medicare for individual E/M services using 1 of 10 E/M CPT codes for office visits, depending on the complexity of the medical decision making or the time spent with the patient and whether the office visit is with a new or established patient.¹² Providers may select one of five E/M service levels for both new and established patients based on either the level of complexity of medical decision making or the time spent with the patient. For instance, if providers decide to select E/M CPT codes to bill E/M services based on the level of complexity of medical decision making, they may select higher level E/M CPT codes when the complexity of establishing a diagnosis or selecting a management option is higher. In addition, if providers decide to select E/M CPT codes to bill E/M services based on the time spent with the patient, the time defined in the service descriptors is used for selecting the appropriate level E/M CPT codes.¹³

An office visit with a new patient can be billed using one of five E/M CPT codes, from 99201 (the lowest complexity level or time spent code) to 99205 (the highest complexity level or time spent code).¹⁴ An office visit with an established patient can be billed using one of five E/M CPT codes, from 99211 (the lowest complexity level or time spent code) to 99215 (the highest complexity level or time spent code). Appendix B shows the E/M CPT codes and their descriptions.

Billing Medicare for Evaluation and Management Services Provided via Telehealth

Although telehealth services were paid at the same rate as in-person services during the PHE, CMS revised the Medicare billing guidance for telehealth services. To bill Medicare for an E/M service provided via telehealth before March 1, 2020, a provider was required to include place of service code 02 on the claim to indicate that the service was provided through telecommunication technology.¹⁵ To bill Medicare for E/M services provided via telehealth with dates of services on or after March 1, 2020, and for the duration of our audit period, providers should have submitted claims that included the place of service code that would have

¹² The Secretary adopted the CPT, Fourth Edition (CPT-4) as the standard medical data code set, maintained and distributed by the AMA for physician services, for the period on and after Oct. 1, 2015 (45 CFR §§ 162.1002(a)(5) and 162.1002(c)(1)).

¹³ Beginning on Mar. 1, 2020, time alone can be used to select the appropriate code level for the office or other outpatient E/M CPT codes.

¹⁴ Beginning Jan. 1, 2021, CPT code 99201 is no longer in use.

¹⁵ CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 12, § 190.6.1.

been billed had the service been provided in-person and added modifier 95 to indicate that the service was provided via telehealth.^{16, 17}

Providers could have also used the following modifiers listed below to bill for telehealth services:

- Modifier GT indicates that the critical access hospital method II service was provided via interactive audio and video telecommunications systems.¹⁸
- Modifier GQ indicates that the service was provided via asynchronous (store and forward) telecommunications systems.¹⁹
- Modifier G0 indicates that the service was a telehealth service provided for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

Documentation of Evaluation and Management Services

CMS has issued guidelines for physicians to use when determining and documenting the appropriate level of an E/M service. These guidelines outline what information is necessary to include in the medical record to support the level of an E/M service. There are two versions of the documentation guidelines, the *1995 Documentation Guidelines for Evaluation and Management Services* (1995 E/M documentation guidelines) and the *1997 Documentation Guidelines for Evaluation and Management Services* (1997 E/M documentation guidelines).

The 1995 and 1997 E/M documentation guidelines outline the general principles of documentation that are applicable to all types of medical and surgical services in all settings. For E/M services, the nature and amount of physician work and documentation varies by type of service, place of service, and the patient's status. E/M documentation should generally

¹⁶ 85 Fed. Reg. 19230, 19233 (Apr. 6, 2020); CMS's Medicare Learning Network (MLN) Matters No. SE20011 (Sept. 8, 2021).

¹⁷ A modifier is a two-character code reported with a HCPCS or CPT code and is used to give Medicare additional information needed to process a claim (*National Correct Coding Initiative Policy Manual for Medicare Services*, chapter I, § E(1) and *Medicare Claims Processing Manual*, chapter 23, § 20.3).

¹⁸ A critical access hospital is a hospital certified under a specific set of Medicare conditions of participation, which are structured differently than the acute-care hospital conditions of participation. A critical access hospital may elect the method II payment option for outpatient professional services, which allows the hospital to be paid 115 percent of what it would otherwise be paid under the Medicare fee schedule.

¹⁹ For Federal telemedicine demonstration programs conducted in Alaska or Hawaii, asynchronous store-and-forward technologies may be used as a substitute for an interactive telecommunications system (42 CFR § 410.78(d)). These technologies transmit a patient's medical information from an originating site to a provider at a distant site (42 CFR § 410.78(a)(1)).

conform to the following general principles, taking into account variable circumstances in providing E/M services:

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include: reason for encounter and relevant history, physical examination findings, and prior diagnostic test results; assessment, clinical impression, or diagnosis; plan for care; and date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT codes reported on the health insurance claim form should be supported by the documentation in the medical record.

The 1995 and 1997 E/M documentation guidelines and the American Medical Association's (AMA's) *2020 AMA CPT Codebook Evaluation and Management Services Guidelines* (AMA CPT Codebook guidelines) levels of E/M services section states that the descriptors for the levels of E/M services recognize seven components. These seven components are: (1) History, (2) Examination, (3) Medical decision making, (4) Counseling, (5) Coordination of care, (6) Nature of presenting problem, and (7) Time.

The 2020 Physician Fee Schedule Final Rule (84 Fed. Reg. 62568, 62844 (Nov.15, 2019)) stated that effective January 1, 2020, when coding and billing E/M visits to Medicare, providers may use one of two versions (the 1995 or 1997 E/ M documentation guidelines) for a patient encounter. Further, this Final Rule explains that these guidelines specify the medical record information within each of the three key components (such as number of body systems reviewed) that serves as support for billing a given level of E/M service. The Final Rule explains that the 1995 and 1997 guidelines are very similar to the guidelines for E/M visits that are currently located within the AMA CPT Codebook guidelines. For example, the core structure of what comprises or defines the different levels of history, exam, and medical decision making in the 1995 and 1997 E/M documentation guidelines are the same as those in the CPT codebook. However, the Final Rule explains that the 1995 and 1997 E/M documentation guidelines include extensive examples of clinical work that comprise different levels of medical decision making that do not appear in the AMA CPT Codebook guidelines. Also, the 1995 and 1997 E/ M

documentation guidelines do not contain references to preventive care that appear in the AMA CPT Codebook guidelines.

This Final Rule also stated that effective January 1, 2021, providers could choose to document E/M services using medical decision making or time, or providers could use the current framework based on the 1995 or 1997 E/M documentation guidelines (84 Fed. Reg. at 62846). In addition, the Interim Final Rule regarding the response to the PHE effective March 1, 2020, made payment, policy, and programmatic changes intended to give providers flexibilities needed to respond effectively to the PHE. For example, the level of service for office outpatient visits furnished via telehealth may be based on time or medical decision making. Finally, documentation requirements for history and physical exam have been removed for office outpatient visits furnished via telehealth. CMS explained that this policy is similar to the policy that applied to E/M services beginning in 2021 under policies finalized in the 2020 Physician Fee Schedule Final Rule (85 Fed. Reg. 19230, 19269 (Apr. 6, 2020)).

The 2020 Physician Fee Schedule Final Rule and the Interim Final Rule regarding the response to the PHE changed how providers select the appropriate level of E/M services. The following year, the 2021 AMA CPT Codebook guidelines were updated to clarify that providers may select the appropriate level of E/M services based on the following:

- the level of the medical decision making as defined for each service, or
- the total time for E/M services performed on the date of the encounter.

Medicare Learning Network's (MLN's) *Evaluation and Management Services Guide*, ICN 006764 (January 2020), provides education and reminds providers that the medical records should be complete and legible and states: "If it is not documented, it has not been done."

Prior Office of Inspector General Work

OIG has issued several reports on telehealth services provided during the PHE. For example, for one study, we developed 7 billing measures that may indicate fraud, waste, or abuse in telehealth services (e.g., billing a high average number of hours of telehealth services per visit) and identified more than 1,700 health care providers whose billing for telehealth services during the first year of the COVID-19 pandemic posed a high risk to Medicare. We determined that all of these providers warrant further scrutiny because they may have billed for telehealth services that were not medically necessary or were never provided.²⁰ These providers billed for telehealth services (e.g., office visits) for about half a million Medicare enrollees and received a total of \$127.7 million in Medicare fee-for-service payments. Another study found that more than 2 in 5 Medicare enrollees used telehealth services during the COVID-19 pandemic, and enrollees used 88 times more telehealth services during the first year of the pandemic

²⁰ *Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks* ([OEI-02-20-00720](#)), Sept. 7, 2022.

(March 2020 through February 2021) than they used in the prior year.²¹ See Appendix C for a list of related OIG reports.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$1.4 billion in Medicare Part B payments for more than 19 million E/M claim lines of services (E/M services) that were billed with place of service codes or modifiers indicating telehealth was used to provide the service during the first 9 months that access to telehealth was expanded (our audit period, from March 2020, through November 2020). We selected a stratified random sample containing three strata of E/M services provided via telehealth during the audit period.²²

We requested supporting documentation from the providers for E/M services included in our sample. We reviewed the supporting documentation to determine whether providers met Medicare requirements, guidelines, and guidance when billing for E/M services provided via telehealth. However, we did not determine whether the services were medically necessary or assess the quality of care provided to enrollees. We also reviewed the supporting documentation to obtain information on how providers documented telehealth services provided during our audit period. Finally, we reviewed the E/M documentation guidelines, 2020 Physician Fee Schedule Final Rule, the Interim Final Rule regarding the response to the PHE, and AMA guidelines.

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 details of our audit scope and methodology, Appendix D contains details of our statistical sampling methodology, and Appendix E contains our sample results.

FINDING

Physicians and other practitioners that provided E/M services via telehealth generally complied with Medicare requirements. For 105 of the 110 sampled E/M services provided via telehealth, providers complied with Medicare requirements. However, for the remaining five sampled E/M services, providers did not comply with Medicare requirements. Medicare paid \$446 for the five sampled E/M services for which providers did not document or insufficiently documented the services.

²¹ *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic* ([OEI-02-20-00520](#)), Mar. 15, 2022.

²² To identify E/M services that were billed as telehealth services, we identified claim lines that included telehealth indicators (i.e., place of service code 02 or with modifiers GT, GQ, GO, or 95).

We also identified potential documentation issues in the medical records used to support the sampled E/M services that we discuss in the Other Matters section of this report.

PROVIDERS GENERALLY MET MEDICARE REQUIREMENTS WHEN BILLING FOR EVALUATION AND MANAGEMENT SERVICES PROVIDED VIA TELEHEALTH

For 5 of the 110 Medicare Part B paid claims for E/M services provided via telehealth in our stratified random sample, the providers did not comply with Medicare requirements.²³ Specifically:

- For one of the sample items, the medical record documentation provided was insufficiently detailed to support the billed service.²⁴
- For two of the sample items, the providers stated that no medical record documentation could be provided to support the billed service.
- For two of the sample items, the providers did not submit the medical record documentation to support the billed service despite repeated requests for the records.

The reasons that the E/M services provided via telehealth were not documented or were insufficiently documented were: one provider provided insufficient detail in the medical record, one provider stated the service was billed in error, one provider stated it no longer had access to the record, and two providers did not submit the medical record documentation despite repeated requests for the records.

Medicare paid \$446 for the five sampled E/M services for which providers did not meet Medicare requirements.

CONCLUSION

This report does not have recommendations because providers generally met Medicare requirements when billing for E/M services provided via telehealth and unallowable payments we identified resulted primarily from clerical errors or the inability to access records. We

²³ We did not conduct medical review to determine whether the E/M services were coded at the correct level of service, and we did not review for medical sufficiency. Since we did not use medical review, we assumed that the services performed were medically necessary provided that the information necessary to support the E/M services was reflected in the medical records.

²⁴ Most of the medical records we reviewed contained detailed notes. However, for this sample item, we were unable to verify whether the medical record supported the billed service because the documentation provided to us was mostly illegible and contained little detail (i.e., only a one-page medical record was provided with a few hand-written lines). As a result, we determined that the provider did not furnish information necessary to support the claim as required by the Act § 1833(e).

provided CMS with the details for the five sampled E/M services for which providers did not meet Medicare requirements so they can decide how to resolve them.

CMS elected not to provide comments on our draft report.

OTHER MATTERS: POTENTIAL DOCUMENTATION ISSUES

We identified potential documentation issues in the medical records used to support the sampled E/M services. Some of these documentation issues were specific to E/M services in general, and other documentation issues were specific to telehealth. The potential documentation issues specific to E/M services occurred because CMS has not updated the 1995 and 1997 E/M documentation guidelines or issued new guidelines to reflect the most recent changes announced in the *Federal Register* or existing Medicare guidance. The potential documentation issues specific to telehealth occurred because CMS has not finalized the requirements for services provided via telehealth and, therefore, has not issued guidance for the documentation of telehealth. Although these issues do not currently have an effect on Medicare payments and this report does not contain recommendations related to these potential documentation issues,²⁵ this information may be beneficial to CMS as it considers updating existing documentation guidelines or issuing new guidelines for both E/M services and telehealth (after the permanent telehealth requirements are established).

POTENTIAL DOCUMENTATION ISSUES RELATED TO EVALUATION AND MANAGEMENT SERVICES

We identified potential issues related to the documentation of E/M services. Specifically, these issues were related to time spent on E/M services, patient status, and provider signatures:

- Some providers did not document within the medical records the time spent with the enrollees. The Manual states that documentation should support the level of service reported (Pub. No. 100-04, chapter 12, § 30.6.1 (B)). The 2020 Physician Fee Schedule Final Rule and the Interim Final Rule regarding the response to the PHE changed the options that providers could use to select the level of E/M services. Specifically, in addition to medical decision making the change allowed providers to use time. However, this change was not reflected in the 1995 and 1997 E/M documentation guidelines. The inclusion of this change in any new version of the documentation guidelines CMS issues may help ensure that providers include time spent with the enrollees within the medical records when appropriate.
- Some providers did not document within the medical records that the enrollee was a new or established patient. The Manual defines the phrase “new patient” to mean a patient who has not received any professional services (i.e., E/M services or other face-

²⁵ CMS did not establish different payment rates for CPT codes for E/M services provided through audio-only and provided in-person.

to-face services (e.g., surgical procedure)) from the physician or physician group practice (same physician specialty) within the previous 3 years (the Manual, Pub. No. 100-04, chapter 12, § 30.6.7(A)). However, CMS did not address documenting patient status in the Manual or the 1995 and 1997 E/M documentation guidelines. Since payment amount for E/M services differs depending on whether the patient is new or established, the inclusion of a requirement to include patient status in the medical record documentation in any new version of the documentation guidelines CMS issues may better support billed E/M services.

- Some providers did not sign the medical records. Medicare guidance states that Medicare requires the person responsible for the Medicare enrollee's care to authenticate the services provided. The furnishing provider's signature on a note (i.e., a medical record) indicates that the provider affirms the note adequately documents the care provided (CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.3.2.4). However, CMS did not address signatures in the 1995 and 1997 E/M documentation guidelines. The inclusion of this signature requirement in any new version of the documentation guidelines CMS issues may help ensure that providers comply with the requirements related to provider signatures.

When guidelines are not updated to include requirements or reflect changes, providers are less likely to include those elements in the medical records they prepare, and the documentation is more likely to be inconsistent between providers.

POTENTIAL DOCUMENTATION ISSUES RELATED TO TELEHEALTH

We also identified potential issues related to the documentation of telehealth services. Specifically, providers often documented limited information in medical records related to telehealth.

The potential documentation issues were related to in-person services coded as audiovisual services, audiovisual communication technology, location of service provided, audio-only services coded as audiovisual services and technology issues. Specifically:

- Some of the providers did not document within the medical records how the services were provided, whether via telehealth (audio-only or audiovisual) or furnished in-person. Although this did not affect the payments for these services during our audit period, if providers' do not document whether the services were provided using telehealth or in-person, this may affect CMS and Medicare administrative contractors' (MAC's)²⁶ ability to rely on the claims data for these services and may impact future policy changes if CMS establishes different payment rates for telehealth and in-person services.

²⁶ CMS uses MACs to, among other things, process and pay claims submitted by providers.

- Some of the providers that did indicate that audiovisual technology was used did not always document which audiovisual communication product (e.g., Zoom) was used. Therefore, we could not determine whether telehealth services were provided using an audiovisual communication product that was non-public-facing.²⁷ The lack of information about which communication products were used may be an issue for determining HIPAA compliance.
- Some of the providers did not document within the medical record the location of the provider or enrollee (e.g., provider’s office, provider’s home, or enrollee’s home) when services were provided via telehealth. This information may be beneficial if Federal Medicare geographic restrictions for providers or enrollees are implemented in the future.²⁸
- Some providers documented within the medical records that audio-only technology (i.e., telephone) was used but billed using an audiovisual service CPT code. The CPT codes for audio-only E/M services are separate from the CPT codes for office or outpatient visits that were included in our audit.²⁹ Although providers’ inaccurate coding of these services as audiovisual when audio-only services were provided did not affect the payments for these services during our audit period, it may affect CMS and the MACs’ ability to rely on the claims data for these services and may impact future policy changes.
- Some providers documented within the medical records that the enrollees encountered telehealth related technology issues. Specifically, they documented that these enrollees had unreliable internet connection or lacked access to a device for video. Although the payments for these services were not affected during our audit period, providers’ inaccurate coding of these services as audio and video when audio-only services were provided may affect CMS and the MACs’ ability to rely on the claims data for these services and may impact future policy changes. Guidance could be beneficial to providers on how to document and code services when technology issues occur.

²⁷ A “non-public facing” remote communication product is one that allows only the intended parties to participate in the communication. Non-public facing remote communication products include, for example, platforms such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Whatsapp video chat, Zoom, or Skype. In contrast, public-facing products such as TikTok, Facebook Live, Twitch, or a public chat room are not acceptable forms of remote communication for telehealth because they are designed to be open to the public or allow wide or indiscriminate access to the communication.

²⁸ CMS waived geographic restrictions during the PHE, specifically telehealth originating and geographic site restrictions for telehealth services and allowed patients located in any geographic area both rural and non-rural.

²⁹ CMS allowed CPT codes 99441 through 99443 for E/M services provided via audio-only with dates of service on or after Mar. 1, 2020.

Although the expansion of telehealth services during the PHE improved access to care, it also contributed to risks and vulnerabilities associated with the services provided via telehealth. We are raising these issues for CMS to consider when developing future policies related to Medicare services provided via telehealth.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our nationwide audit covered \$1,375,073,244 in Medicare Part B payments to providers for E/M services that were billed with CPT codes 99201 through 99205 and 99211 through 99215 and either a place of service code 02 or modifiers 95, G0, GQ, or GT indicating telehealth was used to provide the service from March 1, 2020, through November 30, 2020 (audit period). We selected a stratified random sample containing three strata of E/M services provided via telehealth during our audit period. One stratum included 30 E/M services billed as telehealth services provided to new patients and the other two strata each included 40 E/M services billed as telehealth services provided to established patients stratified by provider payment amount. In total, we selected 110 E/M services for review.

We requested supporting documentation from the providers of E/M services included in our sample to determine whether providers documented services in compliance with Medicare requirements and guidance when billing E/M services. We reviewed the E/M services and telehealth information in the supporting documentation provided. For example, we reviewed which types of communication products providers used. We did not conduct medical review to determine if the E/M services were coded at the correct level of service and we did not review for medical necessity.

Our audit objective did not require an understanding or assessment of the internal control structures of CMS or the MACs. Rather, we limited our review to those controls that were significant to our objectives. Specifically, we reviewed CMS's oversight mechanisms for processing Medicare claims for E/M services and telehealth services. For example, we obtained an understanding of CMS's and the MACs' system edits and their policies and procedures for documenting and billing E/M and telehealth services.

We conducted our audit from February 2021 through January 2024.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- communicated with CMS officials to gain a better understanding of the Medicare policies regarding E/M services, including services provided via telehealth;
- analyzed the impact of the telehealth expansion by extracting and comparing data for E/M services provided via telehealth nationwide in calendar years 2019 and 2020;

- extracted from CMS’s National Claims History file the Medicare Part B paid claim lines data for E/M services that were billed with either a place of service code or modifiers indicating telehealth for the audit period;
- created a sampling frame of 19,570,698 E/M services provided via telehealth totaling \$1,375,073,244;
- selected a stratified random sample of 110 E/M services provided via telehealth (Appendix D);
- reviewed data from CMS’s Common Working File and other available data for the sampled E/M services to determine whether the claim lines for the services had been canceled or adjusted;
- requested supporting documentation from the providers;
- reviewed the supporting documentation to determine whether providers complied with Medicare requirements when documenting E/M services provided via telehealth; and
- discussed the results of our audit with CMS officials.

We provided our draft report to CMS on January 10, 2024, for review. CMS elected not to provide comments.

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 upon our audit objectives.

**APPENDIX B: EVALUATION AND MANAGEMENT CURRENT PROCEDURAL TERMINOLOGY
CODES AND DESCRIPTIONS**

| CPT Code³⁰ | Description |
|------------------------------|---|
| 99201 | New patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. |
| 99202 | New patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family. |
| 99203 | New patient office or other outpatient visit. Medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family. |
| 99204 | New patient office or other outpatient visit. Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family. |
| 99205 | New patient office or other outpatient visit. Medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family. |
| 99211 | Established patient office or other outpatient visit. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. |
| 99212 | Established patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. |
| 99213 | Established patient office or other outpatient visit. Medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family. |
| 99214 | Established patient office or other outpatient visit. Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. |
| 99215 | Established patient office or other outpatient visit. Medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family. |

³⁰ The five-character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2019–2020 by the AMA. CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

APPENDIX C: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

| Report Title | Report Number | Date Issued |
|---|--|--------------------|
| <i>Home Health Agencies Rarely Furnished Services Via Telehealth Early in the COVID-19 Public Health Emergency</i> | <u>A-05-21-00026</u> | 9/25/2023 |
| <i>Telehealth During 2020 Helped Ensure End-Stage Renal Disease Patients Received Care, But Limited Information Related to Telehealth Was Documented</i> | <u>A-05-22-00015</u> | 8/1/2023 |
| <i>Montana Generally Complied With Requirements for Telehealth Services During the COVID-19 Pandemic</i> | <u>A-07-21-03250</u> | 5/17/2023 |
| <i>Medicare Improperly Paid Providers for Some Psychotherapy Services, Including Those Provided via Telehealth, During the First Year of the COVID-19 Public Health Emergency</i> | <u>A-09-21-03021</u> | 5/2/2023 |
| <i>Illinois Generally Complied With Requirements for Claiming Medicaid Reimbursement for Telehealth Payments During COVID-19</i> | <u>A-05-21-00035</u> | 12/21/2022 |
| <i>Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic</i> | <u>OEI-02-22-00150</u> | 11/30/2022 |
| <i>The IHS Telehealth System Was Deployed Without Some Required Cybersecurity Controls</i> | <u>A-18-21-03100</u> | 9/7/2022 |
| <i>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</i> | <u>OEI-02-20-00522</u> | 9/2/2022 |
| <i>Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks</i> | <u>OEI-02-20-00720</u> | 9/2/2022 |
| <i>Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic</i> | <u>OEI-02-20-00520</u> | 3/15/2022 |
| <i>Most Medicare Beneficiaries Received Telehealth Services Only From Providers With Whom They Had an Established Relationship</i> | <u>OEI-02-20-00521</u> | 10/18/2021 |

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 19,570,698 claim lines of E/M services totaling \$1,375,073,244 in Medicare Part B provider payments for E/M services that were billed with E/M CPT codes 99201 through 99205 and 99211 through 99215 and either a place of service code 02 or modifiers 95, G0, GQ, or GT indicating telehealth was used to provide the service. The sampling frame included E/M services with payments of \$20.01 through \$199.99 and dates of services during the audit period.

SAMPLE UNIT

The sample unit was a claim line for an E/M service.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing three strata. One stratum included 30 E/M services billed as telehealth services provided to new patients and the other two strata each included 40 E/M services billed as telehealth services provided to established patients. In total, we selected 110 E/M services for review, as shown in Table 1.

Table 1: Frame Description and Sample Size

| Stratum | Patient Status Type | E/M Services Payment Range | Frame Size (Number of E/M Services) | Value of Frame | Sample Size |
|---|----------------------|----------------------------|-------------------------------------|-------------------------|-------------|
| 1 | New Patients | \$20.01 to \$199.99 | 912,166 | \$97,847,065 | 30 |
| 2 | Established Patients | \$20.01 to \$72.65 | 11,688,901 | 639,085,544 | 40 |
| 3 | Established Patients | \$72.66 to \$199.36 | 6,969,631 | 638,140,634 | 40 |
| Total | | | 19,570,698 | \$1,375,073,244* | 110 |
| * The difference in the total is because of rounding. | | | | | |

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the items in each stratum by the Record Link Number³¹ in ascending order and then consecutively numbered the items in each stratum. We generated the random numbers in accordance with our sample design, and we then selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We have chosen not to report any estimates of unallowable payments in the sampling frame because of the low number of unallowable payments found in the sample.

³¹ This field contains a sequentially assigned number for the claims included in the file and allows the user to tie children line items to the parent claim.

APPENDIX E: SAMPLE RESULTS

Table 2: Statistical Sample Summary by Patient Type

| Stratum | Patient Status Type | Frame Size (Number of E/M Services) | Value of Frame | Sample Size | Value of Sample | Number of Incorrectly Billed E/M Services in Sample | Value of Unallowable Payments in Sample |
|---|----------------------------|--|------------------------|--------------------|------------------------|--|--|
| 1 | New Patients | 912,166 | \$97,847,065 | 30 | \$2,988 | 4 | \$381 |
| 2 | Established Patients | 11,688,901 | 639,085,544 | 40 | 2,161 | 1 | 65 |
| 3 | Established Patients | 6,969,631 | 638,140,634 | 40 | 3,541 | 0 | 0 |
| Total | | 19,570,698 | \$1,375,073,244 | 110 | \$8,691* | 5 | \$446 |
| * The difference in total is because of rounding. | | | | | | | |