Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ILLINOIS GENERALLY COMPLIED WITH REQUIREMENTS FOR CLAIMING MEDICAID REIMBURSEMENT FOR TELEHEALTH PAYMENTS DURING COVID-19

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Deputy Inspector General
for Audit Services

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A-05-21-00035

Office of Inspector General

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: December 2022
Report No. A-05-21-00035

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

Illinois Generally Complied With Requirements for Claiming Medicaid Reimbursement for Telehealth Payments During COVID-19

Why OIG Did This Audit

Medicaid telehealth refers to the services provided via a telecommunication system. A Medicaid patient at an originating site uses audio and video equipment to communicate with a health professional at a distant site. Medicaid programs saw a significant increase in telehealth services due to the COVID-19 public health emergency.

Our objective was to determine whether Illinois complied with Federal and State requirements when claiming Medicaid reimbursement for telehealth payments during COVID-19.

How OIG Did This Audit

We reviewed 584,492 Medicaid fee-for-service telehealth payments, totaling $21,052,452 ($13,980,157 Federal share), that Illinois claimed on their March 1, 2020, through March 1, 2021, Federal financial participation Reports. We analyzed the payments looking for trends in the services provided and categorized any unusual or duplicative billing issues. We researched procedure codes and the types of services that can be performed via telecommunication systems. We also contacted providers and reviewed medical records for 230 payments.

What OIG Found

Illinois generally made telehealth payments that were in accordance with Federal and State requirements. Of the 584,492 Medicaid fee-for-service telehealth payments in our population, 583,960 payments were in compliance with the requirements, but the remaining 532 payments were not in compliance with applicable requirements. For 249 payments, the same provider was paid both the originating site and distant site fee. There were 146 payments made as duplicate payments for the same services provided to the same recipient on the same day. Also, 22 of the payments were inaccurately billed as both originating and distant site fees. Finally, providers incorrectly used the telehealth modifier with 35 different procedure codes that are for in-person services. A total of 115 telehealth payments were identified with these codes that could not be performed via telecommunication systems. This noncompliance occurred because the State agency did not adequately monitor compliance. The State agency also did not establish a list of acceptable telehealth procedure codes. Based on our testing, we calculate the unallowable payments totaled approximately $16,154 ($9,832 Federal share) during our audit period.

What OIG Recommends and Illinois Comments

We recommend that Illinois refund up to $9,832 to the Federal Government and enhance the monitoring of provider compliance by conducting periodic reviews of telehealth payments for compliance with requirements. Also, we recommend that Illinois establish a list of acceptable telehealth procedure codes.

Illinois agreed with our findings and provided information on actions that it planned to take to address our recommendations. The actions Illinois described include: (1) reimbursing the Federal Government $9,832, (2) continuing to develop a quality assurance program to review samples of claims, and (3) implementing edits to prohibit inappropriate procedure codes from being billable.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicaid telehealth refers to the services provided via a telecommunication system. A Medicaid patient at an originating site uses audio and video equipment to communicate with a health professional at a distant site.[1] Medicaid views telehealth services as a way to provide medical services between places of lesser and greater medical capability or expertise, or both, for the purpose of evaluation and treatment.

Under the President's national emergency declaration and the Secretary's public health emergency declaration, the Centers for Medicare & Medicaid Services (CMS) has temporarily waived certain requirements and encouraged States to exercise broad flexibilities for the provision of telehealth services to minimize the impact of COVID-19 on health care facilities, decrease community spread of COVID-19, and increase access to medical care. By expanding access to telehealth, people who are self-isolating are allowed to continue medical services from their homes, freeing space in hospitals and other health facilities for COVID-19 patients who require in-person care. Expanding access to telehealth also allows people to continue to receive regular services, such as wellness checks, therapy appointments, and more, while social distancing orders are in place.

Because of the speed with which telehealth has expanded during the COVID-19 pandemic, we maintain the opportunity exists for inefficiencies and potential abuse of the telehealth system. Rapid expansion of telehealth may pose challenges for providers and State agencies, including State oversight of these services.

OBJECTIVE

Our objective was to determine whether the Illinois Department of Healthcare and Family Services (State agency) complied with Federal and State requirements when claiming Medicaid reimbursement for telehealth payments during COVID-19.

BACKGROUND

Administration of the Medicaid Program and Telehealth

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with

[1] See the "Federal And State Requirements" section for definitions of "originating site" and "distant site."

applicable Federal requirements. In Illinois, the State agency administers the Medicaid program.

For purposes of Medicaid, telehealth seeks to improve a patient's health by permitting two-way, real-time interactive communication between a patient at an originating site and a provider at a distant site. States may claim Federal financial participation (FFP) for amounts expended as medical assistance under the State plan.[2]

Telehealth Services in Illinois Prior to COVID-19

Telemedicine is the use of a telecommunication system to provide medical services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location. The interactive telecommunication system must, at a minimum, have the capability of allowing the consulting distant site provider to examine the patient sufficiently to allow proper diagnosis of the involved body system. The telecommunication system must also be capable of transmitting clearly audible heart tones and lung sounds, as well as clear video images of the patient and any diagnostic tools, such as radiographs. Telehealth is defined as the services provided via a telecommunication system.[3]

Telehealth Services in Illinois During COVID-19

The Executive Order signed by the Illinois Governor on March 19, 2020, expands telehealth services in response to COVID-19. The relaxed telehealth requirements were outlined in the Illinois Register.[4] The expanded guidance allows the distant site provider to be any enrolled provider operating within its scope of practice with the appropriate license or certification. Telehealth services are delivered to a patient that is located at an originating site. Any site that allows for the patient to use a communication or technology system may be an originating site, including a patient's place of residence located within or temporarily outside Illinois. However, for a provider to be eligible for the originating site fee, it must be a certified eligible facility or provider organization that acts as the location of the patient at the time a telehealth service is rendered.

Telehealth Reimbursement in Illinois

To be eligible for reimbursement, the telehealth service must be delivered using an "interactive telecommunication system" or "telecommunication system," or other type of communication system where information exchanged between the provider and the patient during the service would be sufficient to meet the requirements of the same service when rendered via face-to-

[2] Social Security Act §1903(a).

[3] In this report, we use the terms telemedicine and telehealth interchangeably.

[4] Illinois Register (volume 44, issue 14, dated April 3, 2020).

face interaction. Reimbursement for telehealth services will be made at the same rate paid for face-to-face services. The distant site provider and originating site provider eligible for a facility fee must maintain adequate documentation of the telehealth services provided.
The Medicaid statute does not recognize telehealth as a distinct service, and States have significant flexibility to establish telehealth payment methodologies and requirements. In Illinois, to bill for telehealth, providers must be licensed to practice medicine in Illinois or the State where the participant is located.

The amount paid to the health professional delivering the medical service is the current fee schedule amount for the service provided. Distant site providers submit claims for telehealth services using the appropriate code for the professional service along with the telehealth modifier "GT." The originating site provider is eligible to receive only a facility fee for telehealth services, billed using Healthcare Common Procedure Coding System (HCPCS) code Q3014. Documentation in the medical records must be maintained at both the distant and originating sites to substantiate the service provided.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 584,492 Medicaid fee-for-service telehealth payments, totaling $21,052,452 ($13,980,157 Federal share), that the State agency included on its FFP Reports with dates of March 1, 2020, through March 1, 2021 (audit period). We analyzed the payments looking for trends in the number of services per person, per day, and by provider. We categorized any unusual or duplicative billing issues that we noted. We made a list of all procedure codes paid as telehealth and researched their descriptions to determine whether those services could be performed via a telecommunication system. We identified 1,502 payments that appeared to be duplicative billing (matching procedure codes, provider, recipient, date of service). We performed additional testing on the matching payments with different modifiers, to determine whether the modifier indicated separate services. We contacted 5 providers and obtained supporting documentation for 230 of these payments. All 230 selected payments appeared to be for distinguishable services.

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

Appendix A contains the details of our audit scope and methodology. Appendix B contains the Federal requirements.

FINDINGS

The State agency generally made telehealth payments that were in accordance with Federal and State requirements. However, the State could establish a list of acceptable telehealth

procedure codes and enhance the monitoring of provider compliance by conducting periodic reviews of telehealth payments. Of the 584,492 Medicaid fee-for-service telehealth payments in our audit period, 583,960 payments were allowable, but the remaining 532 payments were not in compliance with applicable requirements. For 249 payments, the same provider was paid both the originating site fee and distant site fee. There were 146 payments made as duplicate payments for the same services provided to the same recipient on the same day. Also, 22 payments were inaccurately billed as both originating and distant site fees. Finally, providers incorrectly used the telehealth modifier with 35 different procedure codes that are for in-person services. A total of 115 telehealth payments were identified with these codes that could not be performed via telecommunication systems. This noncompliance occurred because the State agency did not give adequately monitor compliance. The State agency also did not establish a list of acceptable telehealth procedure codes. Based on our testing, we calculate the unallowable payments totaled approximately $16,154 ($9,832 Federal share) during our audit period.

FEDERAL AND STATE REQUIREMENTS

Per Federal requirements, FFP is generally available for expenditures under the State plan.[5] Claims for Federal Medicaid reimbursement must be supported by adequate documentation to ensure that all applicable Federal requirements have been met.[6] Additionally, costs must be adequately documented to be allowable under Federal awards.[7]

Per Illinois requirements,[8] telehealth services are performed via a telecommunication system to provide medical services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location. The originating site is the site where the participant receiving the service is located. Originating site providers may receive reimbursement for a facility fee for each telehealth service encounter. To receive reimbursement for the facility fee, originating site providers must bill HCPCS code Q3014 (originating site fee). Conversely, the distant site is the site where the provider rendering the telehealth service is located. Providers rendering telehealth and telepsychiatry services at the distant site shall be reimbursed the State agency's rate for the Current Procedural Terminology (CPT) code for the service rendered. The appropriate CPT code must be billed with modifier GT (via interactive audio/video telecommunication systems).

[5] 42 CFR § 440.2(b).

[6] CMS *State Medicaid Manual* § 2497.1.

[7] 45 CFR § 75.403(g).

[8] 89 Illinois Administrative Code 140.403(a).

THE STATE AGENCY MADE TELEHEALTH PAYMENTS NOT IN COMPLIANCE WITH REQUIREMENTS

Of the 584,492 Medicaid fee-for-service telehealth payments totaling $21,052,452 ($13,980,157 Federal share) in our audit period, the State agency made 583,960 payments totaling $21,036,298 ($13,970,325 Federal share) in compliance with Federal and State requirements. However, the remaining 532 payments were not made in accordance with Federal and State requirements.

The State Agency Made 249 Payments That Did Not Comply With Telehealth Location Requirements

Of the 584,492 Medicaid fee-for-service telehealth payments reviewed, 249 payments totaling $11,311 ($6,994 Federal share) did not appear to comply with telehealth location requirements. For these payments, the State agency paid the same provider for both an originating site fee and the corresponding distant site service for the same recipient. Payments made for an originating site fee and distant site service on the same day, for the same recipient, should have different provider numbers to distinguish the different locations. We are unable to determine which, if any, of the payments are correct without confirmation from the recipient and medical records from all providers involved.

State officials agreed 139 payments appeared to be billing errors. The other 110 payments were for Medicare crossover claims billed by a community mental health center. The State believed the claims were originally reported correctly, but after they crossed through the Medicare system to the Medicaid system, the distant site provider was paid for both the distant and originating site fees. The State could not provide any documentation to support their position.

Providers Were Paid for 146 Services Two Times

From the population of payments, an additional 146 services were paid two times. These duplicate payments show matching provider, beneficiary, procedure code, and date of service. Most of the procedure codes billed were for an "initial 30-minute" individual visit or group intervention. The duplicate services were not always paid the same amount as the first time it was processed. Since we do not know which payment amount is correct, we determined all 292 payments to be in error and included the $4,361 ($2,522 Federal share) in the overpayment section of this report. State officials agreed the providers billed twice in error.

Providers Incorrectly Billed 22 Claims as Both an Originating and Distant Site Service

Another 22 payments totaling $482 ($316 Federal share) were for claims inaccurately coded as both an originating site and distant site. The providers used the HCPCS code for originating site fee but listed the claims as "distant site" and included the GT modifier to indicate distant site.

The providers were paid the originating site fees. State officials could not confirm the nature of these claims and attributed the issue to provider billing errors.

Providers Incorrectly Added the Telehealth Modifier

When we sorted the population of payments by procedure code, we found 189 unique procedure codes labeled with the GT modifier to indicate a telehealth service was provided. Of the 189 codes, 35 are for services that cannot feasibly be performed via a telecommunication system. Some of these procedure codes indicate injections, vaccines, or ultrasounds as the service performed. Providers submitted and the State agency processed 115 payments with these 35 procedure codes and the incorrect telehealth modifier. The distant site providers are reimbursed the same rate for services performed as telehealth, so an overpayment did not occur. Miscoding the 115 payments caused the number of telehealth services performed in Illinois to be overinflated. State officials mentioned they did not have any list of acceptable telehealth procedure codes.

THE STATE AGENCY COULD IMPROVE CONTROLS AND MONITORING OVER TELEHEALTH BILLING

The COVID-19 pandemic and the rapid expansion of telehealth may have posed challenges for the State agency and its providers. While the State generally complied with the broadened telehealth billing requirements, it did not adequately monitor provider compliance by performing periodic reviews of the claims. In addition, the State agency did not establish a list of acceptable telehealth procedure codes. This resulted in payments for services that could not be provided in a telehealth setting, as well as other telehealth billing errors.

RECOMMENDATIONS

We recommend that the State agency:

- refund up to $9,832 to the Federal Government,
- enhance the monitoring of provider compliance by conducting periodic reviews of telehealth payments for compliance with requirements, and
- establish a list of acceptable telehealth procedure codes.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Illinois concurred with our recommendations and described the actions that it has taken or plans to take to address them. The actions Illinois described include: (1) reimbursing the Federal Government $9,832, (2) continuing to develop a quality assurance program to review samples of claims, and (3) implementing edits to prohibit inappropriate procedure codes from being billable. Illinois' comments are included in their entirety as Appendix C.

We recognize the corrective actions Illinois has implemented or plans to implement to address our recommendations. These corrective actions should provide improved compliance with telehealth billing requirements.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 584,492 Medicaid fee-for-service telehealth payments, totaling $21,052,452 ($13,980,157 Federal share), that providers billed and were reimbursed for on the FFP Reports from March 1, 2020, through March 31, 2021.

We performed our audit fieldwork at the State agency office in Springfield, Illinois, from August 2021 through November 2022. We did not assess the State agency's overall internal control structure. Rather, we limited our audit of internal controls to those applicable to our audit objective.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed State laws, regulations, and guidance, including the Illinois Register and Illinois Administrative Code;
- interviewed State officials and providers to gain an understanding of telehealth in Illinois;
- analyzed all 584,492 Medicaid fee-for-service payments to discover unusual or duplicative billing;
- researched the 189 procedure codes paid as telehealth services;
- identified 1,502 payments that appeared to be duplicative billing (same provider, recipient, procedure code, date of service);
- selected 230 of the 1,502 payments for further testing to ensure modifiers indicated separate services;
- contacted 5 providers to request supporting documentation for the 230 payments and reviewed the medical records to ensure they were separate services; and
- discussed our findings with State officials.

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

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: FEDERAL REQUIREMENTS

FEDERAL REQUIREMENTS

Section 1903(a) of the Act states:

> From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f)) of the total amount expended during such quarter as medical assistance under the State plan.

42 CFR § 440.2(b) states: "Definitions of services for FFP purposes. Except as limited in part 441, FFP is available in expenditures under the State plan for medical or remedial care and services as defined in this subpart."

45 CFR § 75.403 states: "Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards . . . (g) Be adequately documented."

CMS's *State Medicaid Manual* § 2497.1 states: "Federal financial participation (FFP) is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met."

APPENDIX C: STATE AGENCY COMMENTS

HFS
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December 13, 2022

Department of Health and Human Services
Office of Audit Services, Region V
Attn: Sheri L. Fulcher, Regional Inspector General for Audit Services
223 North Michigan Avenue, Suite 1360
Chicago, IL 60601

Re: Draft Audit Report A-05-21-00035

Dear Ms. Fulcher:

Thank you for providing the opportunity to comment on your draft audit report entitled "*Illinois Generally Complied with Requirements for Claiming Medicaid Reimbursement for Telehealth Payments During COVID-19*".

The Department concurs with the three recommendations noted in the draft audit report. Regarding recommendations one, the Department agrees to reimburse the Federal Government $9,832.

Regarding recommendation two, and in response to a previous telehealth audit, the Department is in the process of developing a quality assurance program to review a focused sample of telehealth claims to determine the accuracy of the claim submissions. We met with our Office of Inspector General last week regarding sample size and selection criteria.

Regarding finding three, the Department is reviewing the procedures codes that were billed to the Department during the Public Health Emergency, for their appropriateness. The Department will implement editing to prohibit inappropriate procedure codes from being billable.

We appreciate the work completed by your audit team and the open lines of communication with HFS staff throughout this audit. If you have any questions or comments about our response to the audit, please contact Amy Lyons, External Audit Liaison, and (217) 558-4347 or through email at amy.lyons@illinois.gov.

Sincerely,

Theresa Eagleson
Director

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