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**Office of Inspector General**



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April 2026 | A-05-23-00001

# **CMS Could Strengthen Medicare Program Safeguards To Prevent and Detect Potentially Improper Payments for Virtual Check-in and E-visit Services**



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### Why OIG Did This Audit

- [CMS](#) has sought to improve access to virtual care by introducing communication technology-based services, such as virtual check-in services and electronic visit services (e-visits). One of the benefits of virtual care is the ability to provide services to Medicare enrollees when access to in-person care is limited.
- We conducted this audit to determine whether there are vulnerabilities that might result in improper payments for virtual care services and opportunities to reduce the risk of improper payments.

### What OIG Found

CMS paid providers for virtual check-in and e-visit services during our audit period that may not have complied with Medicare requirements. Specifically:

- CMS made \$1,964,125 in potential improper payments for 173,287 virtual check-in services that occurred within 7 days after or 24 hours (1 day) prior to an evaluation and management (E/M) service having the same diagnosis code for the same enrollee. Of these, 120,316 E/M services were also billed and paid with an unnecessary modifier.
- CMS made \$298,200 in potential improper payments for 10,237 e-visit services because the services were provided within 7 days of another e-visit having the same diagnosis code for the same enrollee.

Medicare made potentially unallowable payments to providers for virtual check-ins and e-visit services because CMS and Medicare Administrative Contractors did not have system edits in place to detect certain payments at risk for noncompliance; nor did CMS educate providers on the proper billing requirements for virtual check-in and e-visit services.

### What OIG Recommends

We made three recommendations to CMS, including that it develop system edits for billing communication technology-based services that could have saved the Medicare program up to \$2.3 million during our audit period, strengthen the Healthcare Common Procedure Coding System code descriptions for virtual check-ins in the Physician Fee Schedule, and further educate providers on the proper billing requirements for virtual and e-visit services. The full recommendations are in the report.

CMS concurred with our first and third recommendations and described corrective actions it planned to take, or has already taken, to address the recommendations. CMS did not concur with our second recommendation.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

The Centers for Medicare & Medicaid Services (CMS) has sought to improve access to virtual care by introducing communication technology-based services, such as virtual check-in services and electronic visit services (e-visits). One of the benefits of virtual care is the ability to provide services to Medicare enrollees when access to in-person care is limited. We conducted this audit to determine whether there are vulnerabilities that might result in improper payments for virtual care services and opportunities to reduce the risk of improper payments.

### OBJECTIVE

The objective of our audit was to determine whether providers that received payments for virtual check-in and e-visit services complied with Medicare requirements.

### BACKGROUND

#### The Medicare Program

The Medicare program provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. Medicare Part B provides supplementary medical insurance for medical and other health services, including communication technology-based services. CMS administers Part B and contracts with Medicare Administrative Contractors (MACs) to, among other things, determine payment rate amounts and pay claims, conduct audits, safeguard against fraud and abuse, and educate providers about Medicare billing requirements.

MACs submit Medicare Part B provider claims that they received from providers to CMS's centralized Common Working File (CWF) system for prepayment validation. As part of the validation process, the CWF performs a series of automated system edits that make a claim approval, adjustment, or rejection determination. This can include checking for modifiers such as those for separately billable services.

#### Communication Technology-Based Services

In 2019, CMS began to increase Medicare enrollees' access to physicians' services via communication technology by recognizing a discrete set of services defined by and inherently involving the use of communication technology. These services include certain kinds of remote patient monitoring (either as separate services or as parts of bundled services) and

interpretations of diagnostic tests (when furnished remotely). CMS introduced virtual check-in services in its calendar year (CY) 2019 Physician Fee Schedule (PFS)<sup>1</sup> and e-visit services in its CY 2020 PFS.<sup>2</sup>

### *Virtual Check-in Services*

Medicare pays for virtual check-in services for enrollees to communicate with providers and avoid unnecessary trips to providers' offices. These services are for enrollees with an established (or existing) relationship with a provider and for which the communication is not originating from a related evaluation and management (E/M) service within the previous 7 days and does not lead to an E/M service or procedure within the next 24 hours (or soonest appointment available).

Medicare virtual check-in services may only be delivered and billed by providers authorized to furnish E/M services and are furnished through several communication technology modalities, i.e., telephone, audio/video, secure text messaging, email, or use of a patient portal.<sup>3</sup> Providers bill for the services using one of two Healthcare Common Procedure Coding System (HCPCS) codes:<sup>4</sup>

- HCPCS code G2010 is billed when the provider remotely evaluates a captured video or image provided by the enrollee.
- HCPCS code G2012 is billed when the provider responds to an enrollee's concern initiated via audio-only telephone interactions, in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. This service is often used to determine whether an in-person appointment is required.<sup>5</sup>

Figure 1 on the next page shows the amounts that CMS paid for virtual check-in services from 2019 through 2022.

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<sup>1</sup> 83 Fed. Reg. 59452, 59483 (Nov. 23, 2018).

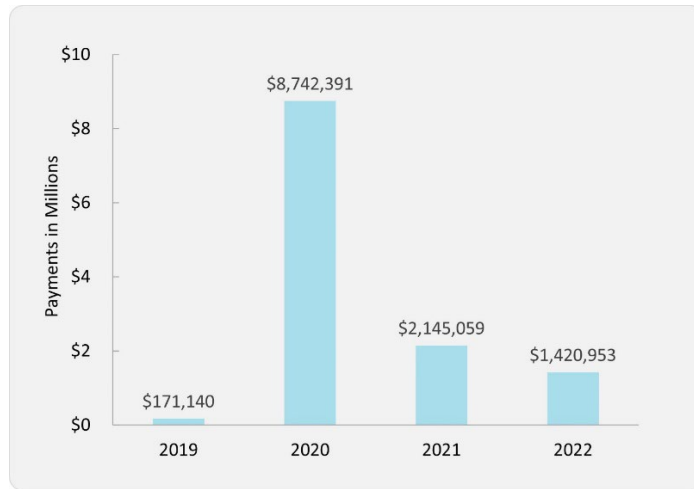
<sup>2</sup> 84 Fed. Reg. 62568, 62797 (Nov. 15, 2019).

<sup>3</sup> Medicare 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 (42 CFR Part 410.20).

<sup>4</sup> On Aug. 17, 2000, 45 CFR § 162.1002 established the HCPCS Level II codes as part of the regulation to implement the Health Insurance Portability and Accountability Act requirement for standardized coding systems. HCPCS codes are used to report medical procedures and services to Medicare, Medicaid, and other health insurance programs.

<sup>5</sup> As of Jan. 1, 2025, CMS CY2025 PFS - 89 FR 97710, 97791 (Dec. 9, 2024), HCPCS code G2012 has been replaced by CPT code 98016. The descriptor for this new code mirrors that for G2012.

**Figure 1: Medicare Virtual Check-in Service Payments, 2019 Through 2022**



### *E-Visit Services*

Medicare enrollees may initiate e-visit services by using online patient portals.<sup>6</sup> The enrollee must generate the initial inquiry, and the communications can occur over a 7-day period. Also, the patient must, on an annual basis, consent to receive e-visit services.

CMS added three Current Procedural Technology (CPT®) codes for e-visit services for providers billing under the PFS.<sup>7, 8</sup> These codes are used to describe patient-initiated digital communication that requires a clinical decision that would otherwise have been provided in an office. An e-visit service should be billed on a claim using a CPT code reflective of the cumulative communication time spent with the patient over 7 days. Figure 2 on the next page shows the e-visit service CPT codes and the associated cumulative communication time over

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<sup>6</sup> An online patient portal is a secure online website that gives patients 24-hour access to personal health information from anywhere, by using a secure username and password.

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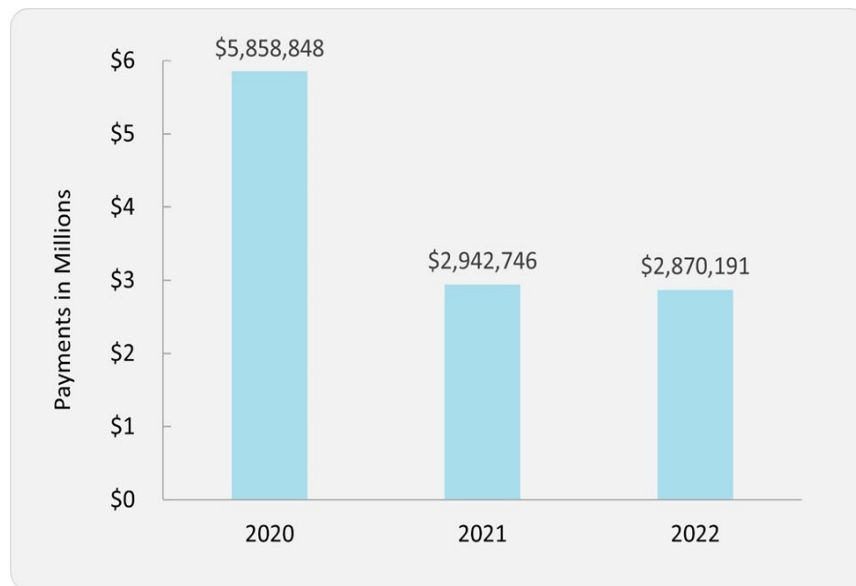
7 days. For example, CPT code 99422 is billed for 11 to 20 minutes of time the provider spent for the visit, or visits, during a 7-day period.

**Figure 2: CPT Codes and Cumulative Communication Time Over 7 Days**

CPT Code <sup>9</sup>	Cumulative Communication Time Over 7 Days
99421	5–10 minutes
99422	11–20 minutes
99423	21 or more minutes

Figure 3 depicts the amount that CMS paid for e-visit services from 2020 through 2022.

**Figure 3: Medicare E-Visit Service Payments, 2020 Through 2022**



### Medicare Requirements for Evaluation and Management Services

E/M services are cognitive services in which physicians or other qualified health care professionals diagnose and treat illness or injury.<sup>10</sup> Medicare covers E/M services when they are reasonable and necessary for the diagnosis and treatment of illness or injury or to improve

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<sup>10</sup> Physicians’ cognitive services involve the application, based on relevant knowledge and experience, of such skills as data gathering and analysis, planning, management, decision making, and judgment relating to the prevention, diagnosis, and treatment of health problems, and communication of such information to the patient.

the functioning of a malformed body member, and the services are documented in the patient's medical record.<sup>11</sup>

### **Provider Submission of Medicare Claims for Part B Services**

Under Medicare Part B, procedure codes and modifiers are used for reporting provider services.<sup>12</sup> Payment rates for provider services are based primarily on CMS's Medicare PFS. Additional rate adjustments may be made or restricted based on the presence of certain modifiers. To receive Medicare Part B payments, a provider must bill for each service performed using the correct procedure code and, if required, append any applicable modifiers. Three modifiers commonly used in billing for health care services are: (1) Modifier 25: significant, separately identifiable E/M service by the same provider or other qualified health care professional on the same day of the procedure or other service; (2) Modifier 95: synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system;<sup>13</sup> and (3) Modifier GT: service rendered via interactive audio and video telecommunications systems.

### **CMS and Medicare Administrative Contractor Claim Processing System Edits**

The MACs submit Medicare Part B physician claims that they receive from providers to CMS's centralized CWF system for prepayment validation. As part of the validation process, the CWF uses edits that check for modifiers such as telehealth (95 and GT) and/or separately billable service (25) modifiers, even on claim lines where a modifier is not required. If a certain modifier is present on the claim line, the claim line will bypass the edits and be paid. According to CMS, the CWF system has no edits in place to reject claims where a modifier should not be appended or was used inappropriately for the claims in our audit.

When there are no edits, CMS in conjunction with the MACs can develop edits primarily through the National Correct Coding Initiative (NCCI). NCCI edits prevent improper payments by ensuring correct coding practices and identifying potentially inappropriate code combinations or quantities. MACs are responsible for implementing these edits within their claim processing systems. There are various types of NCCI edits such as procedure-to-procedure edits. These edits identify combinations of codes that should not be billed together on the same day. They help prevent double billing for services that are inherently included within another code.

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<sup>11</sup> Sections 1862(a)(1)(A) and 1833(e) of the Social Security Act.

<sup>12</sup> A modifier is a two-character code that can be reported with a CPT code and used to give Medicare additional information needed to process a claim (*National Correct Coding Initiative Policy Manual for Medicare Services*, chapter I, § E).

<sup>13</sup> Medicare used modifier 95 during the public health emergency (PHE) to indicate when a service was provided via telehealth. After the PHE, CMS reverted to the place-of-service code to indicate when a service was provided via telehealth and no longer requires modifier 95.

Appendix B contains the details of selected Medicare coverage and payment requirements for communication technology-based services.

## **HOW WE CONDUCTED THIS AUDIT**

Our audit covered Medicare payments totaling \$12,479,542 for 1,341,652 virtual check-in claim lines and \$11,671,785 for 600,235 e-visit claim lines with dates of service from January 1, 2019, through December 31, 2022 (audit period).<sup>14, 15</sup>

For virtual check-in services that were within the previous 7 days and within the next 24 hours (or soonest appointment available) of an E/M service, we identified only claim lines for which the diagnosis code for both the virtual check-in service and the associated enrollee's E/M service were the same. This enabled us to determine whether the virtual check-in service was for the same medical condition, which would make the payment potentially unallowable.

Additionally, using the virtual check-in and E/M services data described above, we identified all E/M claim lines that were billed with a 25, 95, or GT modifier. Modifiers are not required to be used with communication technology-based services, and use of a modifier with corresponding E/M services on a claim can increase the likelihood that the claim line will be improperly paid.

For e-visit services that were within 7 days of each other, we identified claim lines that were billed with the same diagnosis codes to identify whether the e-visit service was potentially unallowable.

For both the virtual check-in and e-visit services, we could not determine with certainty that these claim lines were unallowable because we did not conduct a review of medical records, and the diagnosis code was the only indicator to determine whether these services were billed for a related medical condition that may have originated from or led to an E/M service. However, we concluded that these claim lines may be potentially improper payments based on an assessment of the specific data for each claim when compared to the Medicare requirements.

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

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

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<sup>14</sup> This was the most recent data available at the start of our audit.

<sup>15</sup> CMS did not add e-visit CPT codes until January 2020 (CY 2020 PFS); therefore, there was no claim line data for e-visit services in the first year of our audit period (84 Fed. Reg. 62568, 62797 (Nov. 15, 2019)).

## FINDINGS

CMS paid providers for virtual check-in and e-visit services during our audit period that may not have complied with Medicare requirements. Specifically, CMS made 183,524 potentially improper payments totaling \$2,262,325 for virtual check-in services (\$1,964,125 for 173,287 claim lines) and e-visit services (\$298,200 for 10,237 claim lines).

CMS made these potentially improper payments because CMS and MACs did not have system edits in place to identify communication technology-based services that may have been related to the same medical conditions addressed during other services. Also, providers may not have been aware of CMS requirements for billing these newly created services.

### **VIRTUAL CHECK-IN SERVICE PAYMENTS MAY NOT HAVE MET FEDERAL REQUIREMENTS**

We found that CMS made potentially improper payments for virtual check-in services for which a recent E/M service was billed using the same diagnosis code; therefore, the services appeared to be related to the same medical condition and may have originated from or led to the E/M service. If these virtual check-in services were for the same medical condition, providers should not have billed these services separately. Rather, only an E/M service potentially should have been billed.

Additionally, we noted that many of the E/M service claim lines that were associated with a potentially improperly paid virtual check-in service were billed with a payment modifier. One modifier frequently used (25) indicates a separately identifiable service that bypasses a system edit and results in the provider being paid for the additional service. Other frequently used modifiers (95 and GT) indicate that the service was provided via telehealth and may have resulted in payments for services that should not have been made for the same medical condition as a recent E/M service.

### **Medicare Requirements**

Medicare pays for virtual check-in services for enrollees to communicate with providers and avoid unnecessary trips to providers' offices. According to the 2019 Medicare PFS, these services are for enrollees with an established (or existing) relationship with a provider and for which the communication is not originating from a related E/M service within the previous 7 days and does not lead to an E/M service or procedure within the next 24 hours (or soonest appointment available).<sup>16</sup>

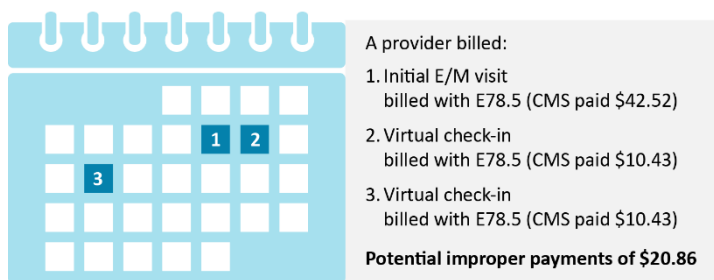
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<sup>16</sup> According to the HCPCS descriptions of a virtual check-in (G2010 and G2012), HCPCS code G2010 is a remote video and/or image, including interpretation with follow-up within 24 business hours, not originating from a related E/M service or procedure within the next 24 hours or soonest available, and HCPCS code G2012 is a brief communication technology-based service not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion.

## Claims for Virtual Check-in Services With Same Diagnosis Code as a Recent Evaluation and Management Service

We identified CMS payments totaling \$1,964,125 for 173,287 claim lines for virtual check-in services associated with 66,899 enrollees that occurred within 7 days after or within 24 hours prior to an E/M service for the same enrollee using the same diagnosis code. If the virtual check-in services were for the same medical condition addressed during the corresponding E/M service, as indicated by the diagnosis code, the virtual check-in services should not have been separately billed because they should have been covered as part of the corresponding E/M service.

For example, a provider saw an enrollee on Thursday, November 5, 2020, and billed for an E/M service with the diagnosis code E78.5—a billable code used to diagnose hyperlipidemia, a condition characterized by high levels of lipids in the blood. CMS paid the provider \$42.52 for the E/M service. The provider also billed and provided two virtual check-in services with the same diagnosis code (E78.5) that Friday and Monday (November 6 and 9, 2020) for \$10.43 each. If these virtual check-in services were related to the same medical condition addressed on November 5, the provider should not have billed separately for the virtual check-in services (totaling \$20.86) since they were within 7 days of the E/M service. Rather, the provider should have billed only the initial E/M service, resulting in a total payment of \$42.52 rather than \$63.38, a potential overpayment of \$20.86.



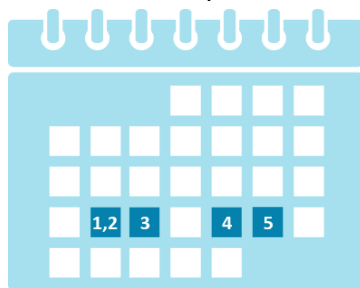
## Inappropriate Use of Modifiers With Evaluation and Management Services

Each of the 173,287 claim lines for virtual check-in services with the same diagnosis code as a recent E/M service had an associated E/M service claim line, of which 120,316 were billed with a payment modifier. We noted that 30,743 claim lines for E/M services were billed with modifier 25, which is used to bill for a significant, separately identifiable service. This modifier bypasses automated prepayment edits in Medicare's prepayment processing system, and use of the modifier seems to contradict the billing requirements in the HCPCS definition for virtual check-in services. By definition, the virtual check-in service is not supposed to originate from a related E/M service within the previous 7 days and is not supposed to lead to an E/M service within the next 24 hours (or soonest appointment available). CMS made potentially improper payments totaling \$337,033 for virtual check-in services because the services were identified as separately billable when they should have been covered as part of the originating E/M service that was provided and billed. (This figure is included in our total calculation of \$1,964,125 of potentially improper payments for virtual check-in services.) We were unable to determine

whether the E/M service or the virtual check-in service was the appropriate service to be billed because we did not review medical records as part of this audit.

For example, a provider billed for an E/M service provided on April 20, 2020, using diagnosis code U07.1, an asymptomatic individual who tested positive and was considered to have the COVID-19 infection, with modifier 25 appended and was paid \$45.49 for that line item. For the same enrollee, the provider billed a virtual check-in service with this same diagnosis code for the same day and was paid \$11.58. This service was within the 7-day window of the E/M service and likely should have been covered as part of the associated E/M service. However, by using modifier 25, the

provider's claim for the E/M service bypassed CMS system edits. As a result, the MAC identified both payments as payable. For this enrollee's next three visits, the provider also billed both an E/M



- A provider billed:
1. E/M visit billed with modifier 25 (CMS paid \$45.49)
  2. Virtual check-in with modifier 25 billed same day (CMS paid \$11.58)
  - 3-5. E/M visit & Virtual check-in with modifier 25 billed next 3 days (CMS paid \$171.21)
- Potential improper payments of \$46.32**

service and virtual check-in service using the same diagnosis code. Payments for the four E/M services totaled \$228.28 rather than \$181.96, a potential overpayment of \$46.32 (for the four virtual check-in services).<sup>17</sup>

For the remaining 89,573 claim lines for the E/M services billed, the claim lines included telehealth modifiers 95 and GT. These modifiers do not impact the associated Medicare payment; they are used to indicate that the service was performed via interactive audio and video communication technology. An E/M service provided via telehealth, and billed with modifier 95 or GT, is similar to a virtual check-in service. Therefore, if both services were billed on a claim for an enrollee, the services appear to be duplicative in nature, and only the E/M payment or the virtual check-in service likely should have been allowed.

For example, on April 28, 2020, a provider billed for a high-level E/M service under code 99215 with a modifier 95 appended to the line item. This modifier indicates that the service was performed via telehealth. The payment for the service is the same whether it was provided via telehealth or in person; however, on the same date of service, the provider also billed HCPCS code G2012 for a virtual check-in. If the E/M service was provided virtually, or in person, it is likely that the service was for the same medical reason as the recent virtual check-in, thereby making the payment for either the E/M service or the virtual check-in improper.

Without a review of the medical records associated with these types of claims, we were unable to verify which payment may be improper. If an edit were put in place to identify claims where both an E/M service and virtual check-in were billed with the same diagnosis code, these types of payments could be denied.

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<sup>17</sup> We did not determine whether the payments for the E/M services were in compliance with Medicare requirements because that was outside the scope of this audit.

## E-VISIT SERVICE PAYMENTS MAY NOT HAVE MET FEDERAL REQUIREMENTS

E-visit services offer quick, safe patient access to virtual health care without needing a scheduled visit, transportation, or time off work. These services are for enrollees with an established (or existing) relationship with a provider and should be billed on a claim using a CPT code reflective of the cumulative communication time spent with the patient over 7 days.<sup>18</sup>

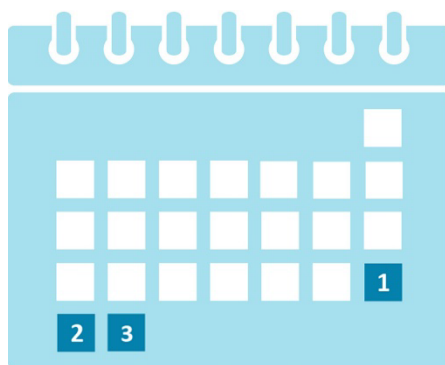
The CY 2020 PFS final rule introduced three CPT codes for e-visit services; CPT 99421 Online digital evaluation and management services for up to 7 days, cumulative time during the 7 days of 5–10 minutes, CPT 99422 for 11–20 minutes, and CPT 99423 for 21 or more minutes.

Using data analysis, we found that CMS made potentially improper payments for individual e-visit services that were performed within a 7-day period of another e-visit service and that were billed using the same diagnosis code. If these e-visit services were billed for the treatment of the same medical condition, they should have been billed with a higher level CPT code encompassing the cumulative interaction time within the 7 days. We found that payments totaling \$298,200 for 10,237 claim lines for e-visit services associated with 6,809 enrollees were potentially improper.<sup>19</sup>

For example, a provider billed three e-visit services for an enrollee that were performed within 7 days of each other and used diagnosis code E11.35—a billable code for Type 2 diabetes mellitus with

proliferative diabetic retinopathy.<sup>20</sup>

Specifically, the provider billed for e-visits on January 29, 2022, with CPT 99423 for more than 21 minutes; January 30, 2022, with CPT 99422 for 11–20 minutes; and again on January 31, 2022, with CPT 99421 for 5–10 minutes.



A provider billed:

1. E-Visit service with CPT 99423 (> 21 minutes)  
(CMS paid \$36.99)
2. E-Visit service with CPT 99422 (11-20 minutes)  
(CMS paid \$22.93)
3. E-Visit service with CPT 99421 (5-10 minutes)  
(CMS paid \$11.63)

**Potential improper payments of \$34.56**

If these visits were for the same medical condition, the provider should have only billed once for the 7-day period based on the cumulative time spent with the enrollee. In this instance,

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<sup>19</sup> If there were multiple claim lines for e-visit services billed within 7 days, we considered the billing of the additional e-visit service(s) to have been potentially improper and used the accumulated time the provider spent treating the patient during a 7-day period to derive the potentially unallowable payment.

<sup>20</sup> People with diabetes can have an eye disease called diabetic retinopathy. This is when high blood sugar levels cause damage to blood vessels in the retina. Proliferative diabetic retinopathy is the more advanced stage of diabetic eye disease. It happens when the retina starts growing new blood vessels.

since all three visits cumulatively exceeded 21 minutes and appeared to be the same medical condition, the provider should have only billed one time (using CPT 99423). Because it billed for three different e-visit services, the provider was paid \$71.55 instead of \$36.99, a potential overpayment of \$34.56.

## **SYSTEM EDITS NOT DEVELOPED TO IDENTIFY POTENTIALLY IMPROPER PAYMENTS**

Medicare made potentially unallowable payments to providers for virtual check-ins and e-visit services because CMS and the MACs did not have system edits in place within the CWF to detect certain payments at risk for noncompliance. CMS's website provided guidance to providers on how to bill these services, but the guidance was limited to the types of providers that could bill for these services, communication modalities that could be used, established patient relationships, and other similar directives. CMS's guidance within the PFS was limited to brief descriptions of the CPT and HCPCS codes and the time interval requirements, which may have led to inconsistent or inaccurate billing by providers. In addition, we found that providers often used modifiers when billing E/M services with associated virtual check-in services. Providers used these modifiers because they were not properly educated on the use of modifiers when billing E/M services. Although the use of these modifiers did not impact the associated payment amount, at least one of the modifiers (modifier 25) could have allowed the providers to bill for both virtual check-in and E/M services on a claim when they should have only been paid for one of the services. Also, CMS did not have system edits in place to identify multiple e-visit services within a 7-day period that were billed using the same diagnosis code.

## **RECOMMENDATIONS**

- We recommend that CMS develop the following system edits for billing communication technology-based services that could have saved the Medicare program up to \$2.3 million during our audit period:
  - (1) edits to identify payments for further review for (a) virtual check-in services that occur within 7 days after or 24 hours prior to an E/M service and are billed with the same diagnosis code and (b) e-visits that occur and are billed separately with the same diagnosis code but should be billed only once within 7 days; and
  - (2) edits to identify and reject claims where virtual check-in services and E/M services are billed on the same claim.
- We recommend that CMS strengthen the HCPCS code descriptions for virtual check-ins in the PFS to clarify the meaning of “related or same medical condition” and “soonest available appointment” to ensure accurate billing of virtual check-ins.
- We recommend that CMS further educate providers on the proper billing requirements for virtual check-in and e-visit services.

## **CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, CMS concurred with our first and third recommendations and described corrective actions it planned to take, or has already taken, to address the recommendations. However, CMS did not concur with our second recommendation as written. After reviewing CMS's comments, we maintain that our second recommendation is valid.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix C.

### **CMS COMMENTS**

CMS concurred with the first recommendation that it develop system edits for billing communication technology-based services. CMS stated that it has implemented system edits to reduce the risk of improper payments for these services. In addition, CMS stated that it will determine whether additional edits or modifications are appropriate based on OIG's findings and recommendations.

CMS did not concur with the second recommendation that it strengthen the HCPCS code descriptions for virtual check-in services in the PFS. CMS stated that it believes this recommendation would be better achieved through language in subregulatory guidance rather than modifications to the code descriptions. CMS stated that it will take OIG's findings and this recommendation into consideration as CMS continues to educate providers on the proper billing requirements for virtual check-ins.

CMS concurred with the third recommendation to further educate providers on proper billing requirements for virtual check-in and e-visit services and stated that it will continue to educate providers.

### **OFFICE OF INSPECTOR GENERAL RESPONSE**

We acknowledge the actions that CMS has taken and plans to take to address the first and third recommendations. We disagree with CMS that the second recommendation can be better achieved through subregulatory guidance because this type of guidance is not legally binding and cannot be enforced.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered Medicare payments totaling \$12,479,542 on 1,341,652 claim lines for virtual check-in services and \$11,671,785 on 600,235 claim lines for e-visit services with dates of service from January 1, 2019, through December 31, 2022 (audit period).

For both the virtual check-in and e-visit services, we could not determine with certainty that these claim lines were unallowable because we did not conduct a review of medical records, and the diagnosis code was the only indicator to determine whether these services were billed for a related medical condition. However, we concluded that these claim lines were vulnerable to being improperly paid.

We did not contact providers associated with the paid claim lines; nor did we have the claims reviewed by an independent medical reviewer to determine medical necessity. Rather, we relied on the diagnoses codes and dates of services contained in the claim data to determine whether the associated claim lines were for the same medical condition to determine whether the virtual check-in and e-visit services complied with Medicare regulations.

We did not assess CMS's overall internal control structure. Rather, we limited our audit of internal controls to those applicable to our audit objective. Specifically, we assessed CMS's oversight activities to identify potentially vulnerable payments made to providers for communication technology-based services, including assessing whether there were any system edits in place for the billing of virtual check-in and e-visit services.

We conducted our audit work from January 2023 through October 2025.

### **METHODOLOGY**

We took the following steps to accomplish our objective:

- Reviewed Federal laws, regulations, and CMS guidance
- Met with CMS program officials to gain an understanding of how virtual check-in and e-visit services are used and billed
- Used CMS's Integrated Data Repository file to identify the following claim lines with dates of service during our audit period:

- Virtual check-in (HCPCS codes G2010 and G2012) services that were provided and paid within 7 days after or 24 hours before an E/M service (CPT codes 99202 through 99215) for the same enrollee<sup>21</sup>
- E-visit (CPT codes 99421 through 99423) services that were provided and paid more than once during a 7-day period for the same enrollee
- Identified claim lines where the diagnosis codes for both the virtual check-in service and the E/M service were the same because they may have been for the same medical condition and therefore potentially unallowable
- Identified all E/M claim lines that contained modifiers 25, 95, and GT in conjunction with a virtual check-in service to determine what effect the modifier had on the payment of the service
- Discussed the results of our audit with CMS officials

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

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<sup>21</sup> CPT copyright 2019 American Medical Association. All rights reserved.

**APPENDIX B: MEDICARE REQUIREMENTS FOR COVERAGE OF  
COMMUNICATION TECHNOLOGY-BASED SERVICES**

**VIRTUAL CHECK-IN SERVICES**

In the CY 2019 PFS final rule (83 FR 59452 through 60303), CMS required separate payment for a number of services that could be furnished via telecommunications technology. Please see the table below for the description of virtual check-in HCPCS codes.

**Table 1: Virtual Check-in Service HCPCS Codes and Descriptions**

HCPCS Code	Description
G2010	Remote evaluation of recorded video and/or images submitted by an established patient, including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
G2012	Brief communication technology-based service by a provider or other qualified health care professional who can report evaluation and management services, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

**E-VISIT SERVICES**

On November 15, 2019, CMS issued CY 2020 PFS, final rule (84 FR 62568 through 63563), effective on or after January 1, 2020.

The CY 2020 PFS final rule is one of several rules that reflect a broader Administration-wide strategy to create a health care system that results in better accessibility, quality, affordability, empowerment, and innovation.

The CY 2020 PFS final rule included new CPT codes for e-visits, which are non-face-to-face patient-initiated digital communications. CPT codes 99421–99423 are for providers that can independently bill E/M services.<sup>22</sup>

Please see the table on the next page for the description of e-visit CPT codes.

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**Table 2: E-Visit CPT Codes and Cumulative Communication Time Over 7 Days**

<b>CPT Code</b>	<b>Description</b>
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

## APPENDIX C: CMS COMMENTS



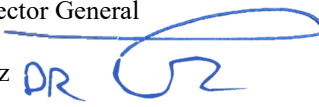
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** February 2, 2026

**TO:** John D. Hagg  
Acting Deputy Inspector General for Audit Services  
Office of Inspector General

**FROM:** Dr. Mehmet Oz   
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report: CMS Could Strengthen Program Safeguards To Prevent and Detect Potentially Improper Payments for Virtual Check-in and E-visit Services (A-05-23-00001)

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 recognizes the importance of providing Medicare beneficiaries with access to medically necessary services, while also working to protect the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing systems, and conducting prepayment and post-payment reviews. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

CMS acknowledges that the use of communication technology has broadened over time and has enhanced the capacity for medical professionals to care for patients. Beginning January 1, 2019, Medicare began paying separately for a discrete set of services defined by and inherently involving the use of communication technology. OIG's audit covered claims that included virtual check-in and e-visit services with dates of services in 2019 through 2022 (the audit period). It is important to note that the audit period covers the initial implementation of these services, as well as the COVID-19 Public Health Emergency (PHE), which likely impacted how services were provided and/or how they were billed during the audit timeframe. CMS has continued to refine the policies and codes associated with these services since the OIG's audit period.<sup>1</sup>

Additionally, CMS has taken action to educate health care providers on the proper billing of Medicare services. For example, during the COVID-19 PHE, CMS published a Medicare Telemedicine Health Care Provider Fact Sheet which includes information on virtual check-in and e-visit services.<sup>2</sup> Additionally, CMS maintained the COVID-19 Frequently Asked Questions

<sup>1</sup> The Medicare Physician Fee Schedule Federal Regulation Notices are available at:

<https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notice>

<sup>2</sup> Medicare Telemedicine Health Care Provider Fact Sheet. Available at: <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>.

(FAQs) on Medicare Fee-for-Service (FFS) Billing which included information on virtual check-in and e-visit services.<sup>3</sup>

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

**OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services develop the following system edits for billing communication technology-based services that could have saved the Medicare program up to \$2.3 million during our audit period:

- (1) edits to identify payments for further review for (a) virtual check-in services that occur within 7 days after or 24 hours prior to an E/M service and are billed with the same diagnosis code and (b) e-visits that occur and are billed separately with the same diagnosis code but should only be billed once within 7 days; and
- (2) edits to identify and reject claims where virtual check-in services and E/M services are billed on the same claim.

**CMS Response**

CMS concurs with this recommendation. Since the OIG's audit period, CMS has implemented system edits to reduce the risk of improper payments, including improper payments for communication technology-based services such as virtual check-in services and e-visits. CMS will determine whether additional edits or modifications are appropriate based on the OIG's findings and recommendation.

**OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services strengthen the HCPCS code descriptions for virtual check-ins in the PFS to clarify the meaning of "related or same medical condition" and "soonest available appointment" to ensure accurate billing of virtual check-ins.

**CMS Response**

CMS does not concur with this recommendation as written. Clarifications regarding the meaning of "related or same medical condition" and "soonest available appointment" would be best achieved through subregulatory guidance, rather than modifications to the code descriptions. CMS will take OIG's findings and this recommendation into consideration as we continue to educate providers on the proper billing requirements for virtual check-ins.

**OIG Recommendation**

The OIG recommends that the Centers for Medicare & Medicaid Services further educate providers on the proper billing requirements for virtual check-in and e-visit services.

**CMS Response**

CMS concurs with this recommendation. CMS will continue to educate providers on Medicare requirements.

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<sup>3</sup> 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>.

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