The OIG Acts on Telehealth

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As the use of telehealth continues to grow throughout the health care industry, government scrutiny of telehealth arrangements is also on the rise. This client alert summarizes two recent examples of this trend from the Office of Inspector General of the United States Department of Health & Human Services (the OIG).

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APRIL 2018 AUDIT REPORT

In April, the OIG published a new report on a post-payment audit of telehealth claims that the Centers for Medicare & Medicaid Services (CMS) processed in 2014 and 2015 (the April 2018 Audit Report). Using a sample of 100 claims, the OIG determined that 31% of the claims CMS paid did not satisfy Medicare requirements for telehealth services. The OIG concluded that non-compliant telehealth claims cost Medicare $3.7 million from 2014-2015.

The most common error, which accounted for over 75% of the problematic claims in the sample CMS analyzed, was that beneficiaries received services at non-rural originating sites. Therefore, those claims failed to satisfy regulatory requirements set forth at 42 C.F.R. § 410.78(b)(4), which outlines acceptable originating sites for Medicare payment purposes.[1] Other issues included ineligible institutional providers submitting claims for payment, services provided using non-permitted methods of communication (*e.g.*, telephone), claims for non-covered services, and services provided by physicians outside of the United States.

ANALYSIS

All indications point to the market for telehealth services continuing to grow, and nearly all state Medicaid programs allow for many services to be provided to their beneficiaries via telehealth. As a result, government scrutiny should remain on the rise, both from the OIG and otherwise. In the April 2018 Audit Report, the OIG recommended that CMS continue to engage in post-payment audits of telehealth claims, and it seems likely that state Medicaid Fraud Control Units (*i.e.*, MFCUs) will follow the example the OIG has set. This is consistent with the OIG's 2017 Work Plan, which also calls for further review of Medicaid payments for telehealth services. Based on the emerging trend of government scrutiny of telehealth arrangements, providers should be diligent in their efforts to comply with all telehealth claim requirements imposed by payers (both public and private). Particular emphasis on original and distant site requirements may also be warranted.

ADVISORY OPINION NO. 18-03

In May 2018, the OIG issued Advisory Opinion 18-03, which evaluated whether a proposal by a federally qualified health center look-alike(the FQHC look-alike) to provide free telemedicine equipment and services (the Proposed Arrangement) to a potential referral source (the Clinic) would violate the federal anti-kickback statute (the AKS). In its analysis, the OIG noted

that the Proposed Arrangement could result in illegal remuneration from the FQHC look-alike to the Clinic in exchange for referrals. On balance, however, the OIG concluded that the arrangement presents a low risk of fraud and abuse and would result in substantial public health benefits. Thus, the OIG concluded that it would not impose sanctions against the parties involved in the Proposed Arrangement.

The Proposed Arrangement involved an FQHC look-alike purchasing a computer, a webcam, and other telehealth equipment for the Clinic, which is located 80 miles away from the FQHC look-alike. The Clinic would use the equipment to treat individuals suffering from human immunodeficiency virus (HIV), and engage in telemedicine encounters related to HIV prevention. The FQHC look-alike proposed to use funds from a state grant dedicated to HIV treatment to fund the purchases involved in the Proposed Arrangement. The OIG highlighted the following factors as relevant to its determination that the Proposed Arrangement posed a low risk of fraud and abuse under the AKS:

Anti-Steering Safeguards. The Clinic receiving the telehealth equipment remained free to refer its patients to any qualified provider, not just the FQHC look-alike donating the equipment, for HIV-related treatment and consultations. The Clinic also advised its patients that they were free to choose any provider for HIV treatment or consultation, including providers who would see them through an in-person, as opposed to virtual, visit. Finally, the OIG noted that the telemedicine items that the FQHC look-alike donated could be used to connect patients with any provider of health care services, not just the FQHC look-alike. The OIG viewed each of these factors as a protection against the Proposed Arrangement restricting patient choice and instead funneling referrals to the FQHC look-alike.

No New Services. The OIG noted that whether or not the Clinic received the telehealth equipment at issue in the Proposed Arrangement, the Clinic would have performed the preliminary tests and referred clinically appropriate patients for consultations and other services. As a result, the OIG reasoned that the risk of overutilization – a common concern of regulators concerning services delivered via telehealth – was mitigated. The donation of the telehealth equipment made it more likely that patients would receive follow-up care that they may struggle to access in a rural setting.

Promote Public Health. The OIG also weighed the increased access to preventative HIV services that the Clinic's patients would have under the Proposed Arrangement, which "could reduce the prevalence of HIV and promote public health."

Patients as the Primary Beneficiaries. Finally, the OIG looked favorably upon the fact that, while the Clinic and the FQHC look-alike might benefit from the Proposed Arrangement, the "primary beneficiaries" would be the Clinic patients who could receive HIV prevention services "more conveniently and efficiently" thanks to the telehealth equipment at issue.

ANALYSIS

By most accounts, the predominant challenge for providers treating patients via telemedicine today is limited Medicare reimbursement. The Bipartisan Budget Act of 2018 will introduce some improvements beginning in 2019, but progress remains relatively slow on this front from the perspective of telehealth advocates. Looking to the March 2018 MedPAC report to Congress on telehealth services and the Medicare program, it seems unlikely that sweeping moves to cover broad swaths of services provided to Medicare beneficiaries via telehealth are on the horizon.

CMS, however, supports telehealth in some contexts more than others. CMS has long viewed telemedicine as a tool to combat barriers preventing patients in rural environments from accessing health care, [2] and Advisory Opinion 18-03 is consistent with that trend. Advisory Opinion 18-03 demonstrates the OIG's willingness to view arrangements that could implicate federal fraud and abuse laws in their most positive light when such arrangements can create substantial public health benefits, such as the access to HIV treatment and preventive care for patients at the Clinic.

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Hooper, Lundy & Bookman's telehealth attorneys will continue monitoring telehealth developments at the state and federal levels. For more information, please contact Jeremy Sherer in Boston, Charles Oppenheim in Los Angeles, Steve Phillips in San Francisco, Jennifer Hansen in San Diego, or Bob Roth in Washington, D.C.

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[1] An originating site references the location of the patient at the time that they receive treatment via telehealth.

[2] *See, e.g.,* 42 C.F.R. § 410.78(b)(4) (requiring that originating sites where Medicare beneficiaries receive services via telehealth be in rural areas or part of a telehealth demonstration project).

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