



In the News

Report Dissects Fraud Risk in Telehealth Services Billed to Medicare

Joan Stephenson, PhD

Only a small share of clinicians who billed Medicare for telehealth services early in the COVID-19 pandemic had “concerning” billing practices that raised red flags indicating possible fraud, waste, or abuse, according to a [new report](#) from the Department of Health and Human Services’ Office of Inspector General (OIG).

Nonetheless, the OIG’s analysis found that the clinicians identified as presenting a “high risk to Medicare” billed for telehealth services for about half a million patients at a total cost of nearly \$128 million in Medicare fee-for-service payments for telehealth services that might have been unnecessary or not even delivered to patients.

Early in the COVID-19 pandemic, the Centers for Medicare & Medicaid Services (CMS) made changes to Medicare policies, waiving certain [restrictions](#) to temporarily expand access to telehealth services for Medicare beneficiaries.

For example, for people covered under traditional Medicare, prepandemic coverage of telehealth services was limited to people living in rural areas, with restrictions on where they could receive these services (at qualifying sites rather than in their own homes). The easing of these restrictions meant that beneficiaries could use telehealth to access services at different locations, including in urban areas and from home.

Other changes during the pandemic included an increase in the types of services that Medicare beneficiaries could use via telehealth, from 118 to 264 services. In addition to expanding access by loosening restrictions, CMS temporarily paused several “program integrity activities,” including medical reviews of claims.

Aided by these changes, telehealth use surged dramatically in 2020, the first year of the pandemic. According to a [related OIG report](#) released in March 2022, more than 28 million beneficiaries—more than 2 in 5—used telehealth for health care that year. “In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they used in the prior year,” the report said.

However, as a permanent expansion of access to telehealth services is being considered by Congress, some legislators have [expressed concerns](#) about the potential for fraud.

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

The OIG analyzed Medicare fee-for-service claims data and Medicare Advantage encounter data for the first year of the pandemic, from March 1, 2020, to February 28, 2021. In all, approximately 742 000 individual clinicians billed for telehealth services.

The OIG found evidence that only a relatively small share of clinicians—1714 of 741 759—were billing for virtual care in a potentially fraudulent way. These individuals billed for telehealth services for about half a million beneficiaries, receiving a total of nearly \$128 million in Medicare fee-for-service payments. Each of them had “concerning billing” on at least 1 of 7 measures that may indicate fraud, waste, or abuse, such as billing for telehealth services that were not medically necessary or that were never provided.

For example, 1 of the measures that is a red flag for potential fraud is billing inappropriately for both a telehealth service and a facility fee for most visits, which would mean that the clinician and

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patient were at the same physical location where the telehealth service was provided—a circumstance in which a telehealth visit should not have occurred. The OIG investigation found that 672 clinicians billed for both a telehealth service and a facility fee for about 148 000 visits, for a total cost of more than \$14.3 million.

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

The other 6 measures suggesting possible fraud include billing telehealth services at the highest, most expensive level every time; billing telehealth services for a high number of days in a year; billing both Medicare fee-for-service and a Medicare Advantage plan for the same service for a high proportion of services; billing a high average number of hours of telehealth services per visit; billing telehealth services for a high number of beneficiaries; and billing for a telehealth service and ordering medical equipment for a high proportion of beneficiaries.

A total of 365 clinicians always billed telehealth services at the highest and most expensive level. "Billing for the highest level of complexity or duration when that is not what was needed or provided is one scheme that unscrupulous providers use to inappropriately increase their Medicare payments," the report notes. "Payments for the highest level range from nearly 2 times to almost 8 times more than the lowest level."

More than half of the "high-risk" clinicians were part of a medical practice with at least 1 other high-risk clinician, which might indicate that certain practices are encouraging such billing practices. The OIG found that in some cases, clinicians who billed at the highest levels were concentrated in specific medical practices.

"In total, 21 medical practices had multiple providers who always billed at the highest level for telehealth office visits," the report notes. "In one case, a single medical practice had 30 providers who always billed at the highest level."

Also, 41 high-risk clinicians appear to be associated with telehealth companies, although the report notes there is currently no systematic way to identify these companies in the Medicare data.

"To improve oversight of telehealth services, it is important that CMS and other oversight agencies be able to identify providers associated with telehealth companies on claims and encounters," the OIG notes. "CMS and others could use this information to more closely monitor these companies and identify companies that pose a risk to the Medicare program."

The relatively small proportion of high-risk clinicians identified by the OIG investigators suggests that targeted oversight of telehealth services could help ensure "that the benefits of telehealth are realized while minimizing risk," the report says.

The OIG says that it is advising CMS to follow up on the clinicians that the OIG identified as posing a high risk to Medicare—noting that CMS agreed to do so—and recommends that CMS take steps to further educate clinicians on appropriate billing practices.

In addition, the OIG recommends that CMS strengthen monitoring and targeted oversight of telehealth services. It notes that when the agency designs its claims analysis, it could use the 7 measures OIG used in the report, along with others "it deems appropriate."

ARTICLE INFORMATION

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Corresponding Author: Joan Stephenson, PhD, Contributing Editor, *JAMA Health Forum* (Joan.Stephenson@jamanetwork.org).

Author Affiliation: Contributing Editor, *JAMA Health Forum*.

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