

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MONTANA GENERALLY
COMPLIED WITH REQUIREMENTS
FOR TELEHEALTH SERVICES
DURING THE COVID-19
PANDEMIC**

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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Report in Brief

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



Why OIG Did This Audit

Medicaid telehealth refers to the services performed 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.

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

Our objective was to determine whether Montana and Medicaid providers complied with Federal and State requirements when claiming Medicaid reimbursement for telehealth services during the COVID-19 pandemic.

How OIG Did This Audit

Our audit covered 440,003 Medicaid telehealth paid claim lines (lines), totaling \$43.2 million (Federal share), that Montana claimed with paid dates of March 1 through December 31, 2020. We asked Montana to review the procedure codes paid as telehealth and identify which were allowable for billing as telehealth. We reviewed the supporting documentation to determine whether the providers had documentation to support that the services were rendered.

Montana Generally Complied With Requirements for Telehealth Services During the COVID-19 Pandemic

What OIG Found

Montana and Medicaid providers generally complied with Federal and State requirements when claiming Medicaid reimbursement for telehealth services during the COVID-19 pandemic. Over 99.9 percent of the lines we reviewed complied with Federal and State requirements. However, some Medicaid providers claimed services that did not comply with requirements for telehealth services. Specifically, we identified 121 lines totaling \$9,589 (Federal share), each of which had 1 of the following types of errors: documentation did not support that services were performed; services were required to be face-to-face but were instead performed and billed as telehealth; or services were performed but providers incorrectly added a modifier or place of service code to indicate that the services were performed via telehealth.

These errors occurred because Montana's claim payment system did not have edits to ensure that only specific procedure codes eligible to be performed via telehealth were billed as telehealth.

What OIG Recommends and Montana Comments

We recommend that Montana develop and implement edits in its claim payment system so that it pays only telehealth claims whose procedure codes denote the associated services as eligible to be performed via telehealth.

Montana did not provide formal comments on our draft report. However, a Montana official told us that Montana did not have any disagreements with our findings. We will continue to track the recommendation to ensure that Montana takes steps to implement it.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicaid telehealth refers to the services performed 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 of Health and Human Services'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 receiving medical services from their homes, which frees space in hospitals and other health care 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 physical distancing orders are in place.

Because of the speed with which the use of telehealth has expanded during the COVID-19 pandemic, opportunities exist for inefficiencies and potential abuse in 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 Montana Department of Public Health and Human Services (State agency) and Medicaid providers complied with Federal and State requirements when claiming Medicaid reimbursement for telehealth services during the COVID-19 pandemic.

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 "Telehealth Services in Montana During the COVID-19 Pandemic" later in this report for definitions of "originating site" and "distant site."

applicable Federal requirements. In Montana, 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 or Federal share) for amounts expended as medical assistance under the State plan (Social Security Act § 1903(a)). Claims for Federal Medicaid reimbursement must be supported by adequate documentation to ensure that all applicable Federal requirements have been met (CMS *State Medicaid Manual* § 2497.1). Additionally, costs must be adequately documented to be allowable under Federal awards (45 CFR § 75.403(g)).

Telehealth Services in Montana During the COVID-19 Pandemic

The Directive signed by the Governor of Montana on March 20, 2020, expands telehealth services in response to the COVID-19 pandemic. The relaxed telehealth requirements were outlined in a Montana Disaster Relief State Plan Amendment. The expanded guidance allows any enrolled provider operating within its scope of practice, and with the appropriate license or certification, to serve as a distant site provider. Telehealth services are delivered to a patient who is located at an originating site. Any site that allows the patient to use a communication or technology system may be an originating site, including a patient's home.

Telehealth Reimbursement in Montana

To be eligible for reimbursement, the telehealth service must be medically necessary and clinically appropriate for delivery via telehealth. Reimbursement for telehealth services is made at the same rate as that paid for Medicaid health services delivered face-to-face.

The Medicaid statute does not recognize telehealth as a distinct service, and States have significant flexibility to establish telehealth payment methodologies and requirements. In Montana, any Montana health care program provider can bill for telehealth, if that mode of service is appropriate within their license and scope of practice. Additionally, services delivered via telehealth are reimbursable so long as they: (1) are medically necessary and clinically appropriate for delivery via telehealth, (2) comport with the guidelines set forth in the applicable Montana Medicaid provider manual, and (3) are not a service specifically required to be face-to-face as defined in the applicable Montana Medicaid provider manual.

Additionally, if a provider cannot furnish medical records to prove that a service billed to Medicaid was performed and meets all requirements for reimbursement, the service will be deemed not to have been performed, and not reimbursable, because of the lack of documentation, and the State agency will recover all reimbursement paid to that provider. This recovery is permissible regardless of whether the documentation was destroyed or lost due to an event such as (but not limited to) misplaced records, a data processing failure, fire, earthquake, flood, or other natural disaster. The provider must have a backup system in place

to allow recovery of documentation destroyed or lost due to such events or any other cause (Montana Medicaid Disaster Relief State Plan Amendment 20-0024, effective March 1, 2020, and Administrative Rules of Montana (ARM) 37.85.414(1)(g)).

Distant site providers submit claims for telehealth services using the appropriate Healthcare Common Procedure Coding System (HCPCS) code for the professional service along with the telehealth modifier “GT” or place of service code “02.”² The originating site provider is eligible to receive only a facility fee for telehealth services, billed using HCPCS code Q3014.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 440,003 Medicaid telehealth paid claim lines (lines), totaling \$43,231,910 (Federal share), that the State agency claimed with paid dates of March 1 through December 31, 2020 (audit period). We compiled and gave to the State agency a list of all HCPCS codes paid as telehealth. We asked the State agency to review those HCPCS codes and identify which were allowable for billing as telehealth. We used the HCPCS codes that the State agency confirmed were allowable to identify the individual lines to review. We reviewed the supporting documentation to determine whether the providers had documentation to support that the services were performed. We did not review the payments made for services billed using the Q3014 HCPCS code, or their associated services, because of their low dollar amount.

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 and Appendix B contains the Federal requirements.

FINDINGS

The State agency and Medicaid providers generally complied with Federal and State requirements when claiming Medicaid reimbursement for telehealth services during the COVID-19 pandemic. However, some Medicaid providers claimed services that did not comply with requirements for telehealth services. From the list of HCPCS codes that the State agency verified as acceptable services to be performed via telehealth, we identified 121 lines that did not comply with Federal and State requirements. Thus, of the 440,003 lines in our audit scope, 439,882 lines complied with Federal and State requirements (over 99.9 percent), but the remaining 121 lines totaling \$9,589 (Federal share) did not. See the table on the following page.

² HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Table: Summary of Lines Not in Compliance

Type of Noncompliance	Number of Noncompliant Lines
Providers could not provide documentation to support that the service was performed.	8
Service was required to be face-to-face but was performed and billed as telehealth.	26
Providers incorrectly coded service as telehealth; however, service was performed.	87
Total	121

These errors occurred because the State agency’s claim payment system did not have edits to ensure that only specific HCPCS codes eligible to be performed via telehealth were billed as telehealth. According to the State agency, the edits were not in place because of the age of the State agency’s claim payment system and the speed with which telehealth-related changes were rolled out in the COVID-19 pandemic. Additionally, some providers did not always maintain documentation to support services performed. As a result, we identified 121 lines totaling \$9,589 (Federal share) that did not comply with applicable requirements.

THE STATE AGENCY AND PROVIDERS CLAIMED TELEHEALTH SERVICES THAT DID NOT COMPLY WITH REQUIREMENTS

Services for Which Documentation Did Not Support That Services Were Performed

Costs must be adequately documented to be allowable under Federal awards (45 CFR § 75.403(g)). Additionally, claims for Federal Medicaid reimbursement must be supported by adequate documentation to ensure that all applicable Federal requirements have been met (CMS *State Medicaid Manual* § 2497.1). Furthermore, State requirements specify that if a provider cannot furnish medical records to prove that a service billed to Medicaid was performed and that it meets all requirements for reimbursement, the service will be deemed not to have been performed, and not reimbursable, because of the lack of documentation (ARM 37.85.414(1)(g)).

For eight lines, providers billed for services for which documentation did not support that the services were performed. Specifically, for six lines, the supporting documentation did not support that the services were performed. For example, one provider billed for an influenza vaccine; the associated documentation supported other services being provided but did not support the administration of a vaccine. For two other lines, the provider could not furnish any documentation to support that the services were performed.

Services Performed and Billed as Telehealth but Required To Be Performed Face-to-Face

State requirements for telehealth services state that covered services delivered via telehealth are reimbursable so long as such services are medically necessary and clinically appropriate for delivery via telehealth, comport with the guidelines set forth in the applicable Montana Medicaid provider manual, and are not a service specifically required to be face-to-face as defined in the applicable Montana Medicaid provider manual (Montana Medicaid Disaster Relief State Plan Amendment 20-0024, effective March 1, 2020).

For 26 lines, the services were required to be face-to-face but were instead performed via telehealth. For example, for 25 of these lines, the services billed were for mental health partial hospitalization. According to the associated HCPCS codes that the State agency gave us, this type of service must be performed on a face-to-face basis.

Services Performed but Incorrectly Billed as Telehealth

Some of the lines we reviewed did not support that the services were performed via telehealth. Specifically, for 87 lines, we found documentation to support that the services were performed; however, in each case the providers incorrectly added a modifier or place of service code to indicate that the service was performed via telehealth. For example, for two lines, the documentation noted telehealth as the place of service, but the services performed were for alcohol or other drug testing, for which telehealth is not an appropriate place of service.

SOME TELEHEALTH SERVICES DID NOT COMPLY WITH REQUIREMENTS PRIMARILY BECAUSE THE STATE AGENCY DID NOT HAVE EDITS IN PLACE TO ENSURE CORRECT TELEHEALTH BILLING

The COVID-19 pandemic and the rapid expansion of telehealth may have posed challenges for the State agency and its providers. Although the State agency generally complied with the expanded telehealth billing requirements, it did not have edits in place to ensure that only services whose specific HCPCS codes denoted them as eligible to be performed via telehealth were billed as telehealth. According to the State agency, the edits were not in place because of the age of the State agency's claim payment system and the speed with which telehealth-related changes were rolled out in the COVID-19 pandemic. This resulted in payments for services billed as telehealth that could not be performed in a telehealth setting. Although the lack of claims edits did not result in significant overpayments, the potential exists that future overpayments could occur if this vulnerability is not remedied. Additionally, other telehealth billing errors occurred because providers did not always maintain documentation to support that the services were performed.

EFFECT ON PAYMENTS OF TELEHEALTH CLAIMS THAT DID NOT COMPLY WITH APPLICABLE REQUIREMENTS

We identified 121 lines totaling \$9,589 (Federal share) that did not comply with applicable requirements.³ Specifically, for the lines of service that could not be supported, the State agency overpaid providers \$129 (Federal share). For the lines of service that were billed as telehealth but were required to be face-to-face, some of the \$4,250 (Federal share) in associated payments may have been allowable if billed under another HCPCS code, which could affect the amount paid. Finally, for the lines of service performed but incorrectly billed as telehealth, incorrect coding could affect the accurate reporting of \$5,210 (Federal share) in associated payments for telehealth services.

RECOMMENDATION

We recommend that the Montana Department of Public Health and Human Services develop and implement edits in its claim payment system so that the State agency pays only telehealth claims whose HCPCS codes denote the associated services as eligible to be performed via telehealth.

STATE AGENCY COMMENTS

The State agency did not provide formal comments on our draft report. However, a State agency official told us that the State agency did not have any disagreements with our findings. We will continue to track the recommendation to ensure that the State agency takes steps to implement it.

³ Given that audited funds exceeded \$43 million and in light of the *de minimis* amounts in error, we did not make formal recommendations to the State agency to reprocess the claims (and refund the Federal share) that did not comply with requirements. However, we shared the detailed claim information with the State agency to allow it to take appropriate corrective actions.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 440,003 Medicaid telehealth paid claim lines (lines), totaling \$43,231,910 (Federal share), that the State agency claimed with paid dates of March 1 through December 31, 2020 (audit period).

We worked with the State agency to develop a list of HCPCS codes paid as telehealth, to verify the allowability of those HCPCS codes, and we reviewed selected individual lines, their associated payments, and relevant supporting documentation.

We did not review the payments made for services billed using the Q3014 HCPCS code (footnote 2), or their associated services, because of their low dollar amount. We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, we assessed internal controls related to provider submissions of claims for telehealth services using the telehealth modifier or place of service code. However, because our review was limited to this aspect of internal control, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit. Any internal control deficiencies we found are discussed in this report.

We performed our audit work from May 2021 to March 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- interviewed State agency officials to gain an understanding of the provision of and payment for telehealth services in Montana;
- compared Medicaid fee-for-service payment data furnished by the State agency for our audit period to CMS Transformed Medicaid Statistical Information System data obtained by our Division of Data Analytics to ensure the reliability of the claims data that the State agency gave us;⁴
- compiled a list of all HCPCS codes paid as telehealth, gave it to the State agency, and asked the State agency to identify which of those HCPCS codes were allowable for billing as telehealth;

⁴ These CMS data aggregate Medicaid claims data furnished quarterly by State agencies to CMS.

- using the HCPCS codes that the State agency confirmed as allowable, identified payments for services that were not allowable to be performed via telehealth and asked the State agency to give us supporting documentation for these payments;
- performed additional testing on the payments that we had identified, by reviewing the supporting documentation to determine whether the providers had documentation to support that the services were performed via telehealth; and
- discussed our findings with State agency officials on November 30, 2022.

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 AND STATE 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. . . .

Federal regulations state: “*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” (42 CFR § 440.2(b)).

Federal regulations also state: “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” (45 CFR § 75.403).

CMS’s *State Medicaid Manual* 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” (§ 2497.1).

STATE REQUIREMENTS

The Montana Medicaid Disaster Relief State Plan Amendment 20-0024, effective March 1, 2020, states (on pages 5 – 6):

Covered Telemedicine/Telehealth Services

All Montana Medicaid covered services delivered via telemedicine/telehealth are reimbursable so long as a) such services are medically necessary and clinically appropriate for delivery via telemedicine/telehealth, b) comport with the guidelines set forth in the applicable Montana Medicaid provider manual, and c) are not a service specifically required to be face-to-face as defined in the applicable Montana Medicaid provider manual.

Allowable Telemedicine/Telehealth Methods and Technologies

There are no specific requirements for technologies used to deliver services via telemedicine/telehealth and can be provided using: secure portal messaging, secure instant messaging, telephone conversations, and audio-visual conversations.

Requirements for telemedicine/telehealth encounters

- To the extent possible, providers must ensure members have the same rights to confidentiality and security as provided during traditional office visits.
- Providers must follow consent and patient information protocol consistent with those followed during in person visits.
- Telemedicine/telehealth does not alter the scope of practice of any health care provider; or authorize the delivery of health care services in a setting or manner not otherwise authorized by law.
- Record keeping must comply with [ARM] 37.85.414.

ARM 37.85.414(1)(g) states:

If a provider cannot provide medical records to prove that a service billed to Medicaid was provided and meets all requirements for reimbursement, the service will be deemed not to be provided and reimbursable due to the lack of documentation, and the department will recover all reimbursement paid to the provider. This recovery is permissible regardless of whether the documentation was destroyed or lost due to an event such as, but not limited to, misplaced records, a data processing failure, fire, earthquake, flood, or other natural disaster. The provider must have a backup system in place to allow recovery of documentation destroyed or lost due to such events or any other cause.