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Telemedicine: A review of the fraud and abuse landscape

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The practice of telemedicine saw continued advancements in 2018 including, importantly, passage of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act (CHRONIC Act or the Act) as part of the 2018 Congressional Bipartisan Budget Act.[1] The measures passed as part of this bill will help pave the way for Medicare reimbursement for a wider range of telemedicine services, which ultimately may result in further expansion of the availability of these services.

Historically, Medicare reimbursement for telemedicine services has been limited, primarily due to Medicare's conditions for coverage of telemedicine services.[2] These conditions include requiring patients to be located in qualifying rural areas and qualifying "originating sites" (e.g., a hospital or physician's office, but not the patient's home), restrictions on covered Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes, provision of services by eligible "distant site" practitioners, and communication requirements (i.e., real-time audio visual communications). Loosening these limitations, over the next two years, the Act phases in revisions to Medicare's telemedicine reimbursement requirements including: (1) eliminating geographic restrictions on telestroke consultation services; (2) expanding telemedicine coverage under Medicare Advantage plans; (3) permitting Accountable Care Organizations more flexibility in the use of telemedicine services; and (4) permitting monthly telemedicine assessments by a nephrologist from a patient's home for patients receiving home dialysis treatment.

With an increase in federal healthcare spending on telemedicine services, providers can expect increased scrutiny on compliance with federal healthcare program billing and coding requirements, as well as with the requirements of the various fraud and abuse laws that may be implicated by telemedicine arrangements. (For purposes of this article, we are using the term "telemedicine" interchangeably with the term "telehealth.")

For example, in April 2018, the U.S. Department of Health and Human Services Office of Inspector General (OIG) released a report entitled "CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements," a title directly stating the report's conclusion. The report detailed the OIG's findings with respect to whether telemedicine services reimbursed by Medicare met all of the Medicare reimbursement conditions. Medicare paid a total of $17.6 million in telemedicine payments in 2015 out of a total of $540 billion in payments.[3] Based on a review of 100 telemedicine claims, the OIG found that 31 out of 100 claims were improperly paid. The OIG's extrapolation of this result showed that Medicare improperly paid an estimated $3.7 million during the audit period (2014-2015). Although not a large sum in comparison to overall Medicare spending, nevertheless the amount accounts for approximately 27% of all Medicare dollars spent on telemedicine services during this period.

In addition to the OIG's findings, the Department of Justice (DOJ) also appears to be turning its focus to telemedicine-related matters. In October 2018, the DOJ announced an investigation into a nearly $1 billion healthcare fraud scheme involving fraudulent telemedicine services and improperly solicited insurance coverage

information and prescriptions.[4] HealthRight LLC, a telemedicine company, and its CEO pleaded guilty to, among other things, felony conspiracy charges for their roles in the scheme. Charges also were announced against four other individuals and seven companies related to the scheme, which allegedly involved HealthRight fraudulently soliciting insurance coverage information and prescriptions from consumers for prescription pain creams and other similar products. The companies allegedly engaged physicians to prescribe medications via telemedicine encounters, then massively marked up the price of the prescriptions. The prescriptions were then billed to private insurers. Although the scheme described in the DOJ's announcement is a fairly garden-variety case of fraud, the DOJ's announcement is instructive of its increasing interest in oversight of telemedicine activities. Moreover, this interest is likely to increase as more federal healthcare dollars are spent on telemedicine.