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# FQHC Pays $300K to Put Telehealth Error to Rest; M.D.'s Name Was Not On List of Sites

By Nina Youngstrom

In a case at the intersection of technical compliance and telehealth, a federally qualified health center (FQHC) in southeastern Ohio agreed to pay $99,683 to settle allegations it violated the Civil Monetary Penalties Law. Ironton-Lawrence County Community Action Organization billed Medicaid and, to a much lesser extent, Medicare for telepsychiatry services from a site of service that wasn't on its "scope of project," as required by the HHS Health Resources and Services Administration (HRSA), according to the settlement. The FQHC, which self-disclosed the lapse to the HHS Office of Inspector General, also repaid $199,367 to Ohio Medicaid for the same error.

The site of service was the psychiatrist's home, says attorney Daphne Kackloudis, who represented Ironton-Lawrence County Community Action Organization. Although the FQHC already provided psychiatric services in the office setting, it arranged for the psychiatrist to treat patients by telehealth because "there's a general lack of psychiatrists participating in underserved areas," says Kackloudis, with Brennan Manna Diamond. "There probably isn't a psychiatrist who accepts Medicaid in that county."

The psychiatrist's home was across the border in Kentucky. Ohio Medicaid's telehealth rule doesn't prohibit providers in distant sites from providing services from home. But it turned out that was beside the point because the FQHC had a less ambiguous compliance problem. Ironton-Lawrence County Community Action Organization hadn't submitted the psychiatrist's home address to HRSA as a service site on the scope-of-project form (5B), which gets very specific, Kackloudis says. "In trying to provide services to patients, the regulatory structure got in the way," she explains. It wasn't the Ohio rules "that tripped up the FQHC; it was the HRSA rules."

According to the settlement, OIG alleged that from July 28, 2014, through July 31, 2016, the FQHC "presented to Medicaid claims for items or services that Respondent knew or should have known were not provided as claimed and were false or fraudulent."

FQHCs are community-based health care providers that treat patients in underserved areas. They receive enhanced prospective-payment system rates "in exchange for seeing anyone who walks in the door," Kackloudis says. They're regulated by HRSA and must meet its stringent requirements, including the completion of Form 5B. "They are incredibly hyper attentive to detail," she says.

## Conversation at Meeting Leads to Disclosure

The reason Ironton-Lawrence County Community Action Organization wasn't worried about billing for the psychiatrist who provided telehealth from home was because it had reached out to the state medical board and other FQHCs that provide telepsychiatry, and "were told it was fine," she says. It was just a matter of failing to list the service site on Form 5B.

When this came up at an FQHC trade association meeting, Ironton-Lawrence County Community Action Organization realized it had to self-disclose to OIG "because they worried it could create a false claims situation,"

Kackloudis says.

In its self-disclosure, the FQHC "explained this whole situation and the various payers affected by it, which overwhelmingly was Medicaid fee-for-service and managed care," says attorney Ashley Watson, also with Brennan Manna Diamond. There were some Medicare claims too, she says. The FQHC is leaving telepsychiatry alone for now after this experience. Ohio meanwhile this month proposed a new telehealth rule that broadens coverage.

The kind of technical violation that cost the FQHC almost $300,000 is not unlike the "foot faults" that can lead to high-dollar settlements under the Stark Law, says attorney Thomas Ferrante, with Foley & Lardner LLP in Tampa, Florida. In the telehealth arena, providers should pay close attention because OIG already found a high error rate in Medicare in a 2018 audit and plans a Medicaid review this year.

One of the major telehealth mistakes he sees has to do with variations between state medical board rules and the payer source. State medical board rules may be more or less restrictive than Medicare, Medicaid or other payer regulations, Ferrante says. For example, all state medical boards now allow physicians to create new patient relationships using telehealth services without meeting the patient in person first and many allow for a broad range of technologies that the physician may use to establish that relationship (e.g., store & forward/asynchronous technologies that involve pre-recorded, patient-generated still or video images). But state Medicaid programs may have their own standards, Ferrante says. Some Medicaid programs restrict the type of technology a physician can use to establish a physician-patient relationship and require a physician to use real-time audio and video to treat the patient. Similarly, most state medical boards permit patients to get telehealth services in their own home, while some Medicaid programs don't allow telehealth services to be provided in the patient's home and require the patient to be in a facility (e.g., a physician office or a hospital). "The provider may think they are in compliance because they know the medical board rules, but are actually in violation of the Medicaid program rules for reimbursement," Ferrante says.

Every time there's a settlement, "it's sort of a wake-up call for the industry," he says. "As it becomes more accepted, telehealth has to operate like other regulated pieces of health care. A lot of times those who have gotten into health care are more technology oriented and want to operate like Uber—ask for forgiveness, not permission. But it's dangerous to take that approach when asking for government payments. There are strict rules."

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