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Telehealth Risks Come into Focus; Some Payers Don't Cover Audio-Only

By Nina Youngstrom

After the 2021 Medicare Physician Fee Schedule extended coverage of many telehealth services until the end of the public health emergency (PHE), including audio-only visits by physicians and nonphysician practitioners, UofL Health in Louisville, Kentucky, was informed that one of its commercial insurers wouldn't be jumping on that bandwagon. Some commercial payers insist on real-time audiovisual technology for telehealth services to qualify for reimbursement, said Shelly Denham, senior vice president of compliance, risk & audit services. "It's a challenge," she said. "I thought the whole idea is to not make it burdensome to provide telehealth services. We are put in a bad situation when it comes to navigating telehealth" because payers have different rules.

Because it's a matter of a negotiated contract with a commercial payer versus a regulation, however, there's always room for discussion. UofL hopes to persuade the commercial payer to recognize and reconsider its position on audio-only telehealth services. "It's still evolving," Denham said.

These are the kinds of challenges that led UofL to create a telehealth service line and hire a full-time executive director. "We are looking to grow the service line because of COVID-19 and the public health emergency," she said. "We see opportunities for growth in rural areas," which will continue when the PHE ends because Medicare coverage of telehealth is limited by the originating site and rural area requirements without the PHE. The originating site requirement restricts coverage to services delivered to patients at hospitals and other provider locations (not patient homes), and the rural area requirement limits coverage to counties outside a metropolitan statistical area or in a rural health professional shortage area. Only Congress can eliminate these requirements, and several bills have been proposed to that effect. During the PHE, however, Medicare pays for telehealth services in all corners of the country and in patients' homes.

Denham said telehealth audits continue as well, and there are areas ripe for education and documentation improvement. Some areas to pay attention to: the provider's failure to document patient consent in the record and billing for telehealth services that may not qualify as telehealth. Also, in Kentucky, telehealth encounters must be signed in 48 hours. Another problem that has cropped up, and apparently it's not uncommon, is that documentation sometimes makes it seem like the services were delivered in person.

"Services provided by telehealth aren't always documented with the right modifier or the right information to know it's a telehealth versus an in-person visit," said Lori Laubach, a partner in the health care consulting practice at Moss Adams. As an independent review organization, Moss Adams just completed a claims review for a facility that's under a corporate integrity agreement. Some claims have modifiers they shouldn't have because they weren't telehealth services and vice versa. Even without a payment difference, "you should be able to tell which are telehealth services and which aren't."

What Will an Auditor Think Two Years From Now?

The many moving parts of telehealth make it a big compliance risk area. CMS has added telehealth services, some

permanently and others until the end of the year in which the PHE ends,[1] and has been flexible with licensure. The greatest challenge may be keeping track of what telehealth services are covered during the PHE and who may provide them, and ensuring that when the PHE ends, there's documentation to show future auditors that services were provided consistent with CMS and state requirements in place at the time, Laubach said. With a good monitoring system, "you would know why you used those bill types or revenue codes," Laubach said. For example, outpatient occupational, speech and physical therapy provided by telehealth may be billed during the PHE (for dates of service starting March 1, 2020), until the end of the PHE. It's paid separately with the 95 modifier, not bundled into the institutional payment.

There are challenges with workflow "because every organization is set up differently," she said. For example, organizations have to decide how to code and bill when the technology fails and the physician defaults to a phone call, or patients don't have access to a computer or the internet or they are uncomfortable with smartphones or computers. "Make sure the workflows are discussed and captured," Laubach said. "A lot of people don't have broadband, so getting to telehealth is very difficult. People think everyone is on computers, but they're not." When audiovisual technology is available but it's disrupted and the physician and patient switch to a phone call, there has been confusion about whether to bill it with the usual evaluation and management codes or the audio-only codes (CPT 99441-99443) for physicians and nonphysician practitioners. CMS gave some guidance in its answers to COVID-19 frequently asked questions[2] : "Practitioners should report the code that best describes the service. If the service was furnished primarily through an audio-only connection, practitioners should consider whether the telephone evaluation and management or assessment and management codes best describe the service, or whether the service is best described by one of the behavioral health and education codes for which we have waived the video requirement during the PHE for the COVID-19 pandemic. If the service was furnished primarily using audio-video technology, then the practitioner should bill the appropriate code from the Medicare telehealth list that describes the service."

Workflow is one of the telehealth topics addressed in a series of free presentations for ambulatory providers by Telemedicine Hack,[3] a resource provided by Project ECHO and the University of New Mexico, Laubach said.

There also may be concerns that telehealth services don't meet quality of care expectations, she said. "There have been clients who received calls about telehealth services and didn't think anything was solved. All that happened was a chat with a provider." On the flip side, "one provider mentioned to me she is probably doing a better job on quality of care because she can see why the patient is always falling down." The iPhone camera lets the provider see inside the patient's house, and her son gave the provider a tour for potential fall risks. Providers should think through whether telehealth is the right way to deliver care and the substance of their telehealth encounters and perhaps survey patients afterward.

Laubach also recommended mining data to identify telehealth risks, although it's easier said than done. On one project, her first inclination was to pull data with the telehealth modifier, but "it was an exercise in futility. I should be able to find the telehealth modifier, but the government hasn't held you accountable for that." As a result, the universe of telehealth services may not be big enough or accurate. "If you ask for every outpatient, you will have a very large file," she noted. "It was very hard to do." One approach may be a random probe sample to identify which providers are delivering telehealth services in certain departments. Data mining also will turn up anomalies. "I was surprised to see chiropractors in there," she said.

Chart reviews also are foreshadowing compliance problems post-PHE. "During this period, we have seen in chart reviews where providers used telehealth, but the supervision wasn't documented or entered into the system," Laubach said. "We see a future where providers who are not qualified outside the PHE to provide these services" continue when the PHE ends, she said. "Make sure you have controls in place when the PHE ends."

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1 Nina Youngstrom, "Final Physician Rule Changes Supervision, Adds Telehealth Codes, Some Permanently," *Report on Medicare Compliance* 29, no. 43 (December 7, 2020), http://bit.ly/35jzF8w.
2 CMS, "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing," updated February 19, 2021, https://go.cms.gov/2W7cjzj.
3 "Telemedicine Hack," The University of New Mexico, accessed February 25, 2021, http://bit.ly/3pTuwLV.