

# Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic

December 2022



PANDEMIC RESPONSE  
ACCOUNTABILITY COMMITTEE



# Message from the Pandemic Response Accountability Committee

The pandemic changed many aspects of our lives, including how we visit the doctor and other health care providers. Reliance on telehealth services—that is, health care services that are provided remotely using technology between a provider and a patient—skyrocketed during the first year of the pandemic, especially among federal health care programs.

Pandemic Response Accountability Committee’s (PRAC’s) Health Care Subgroup developed this report to share insights about the use of telehealth in selected programs across six federal agencies during the first year of the COVID-19 pandemic.

Together, these programs provided telehealth services to approximately 37 million individuals during that year, a dramatic increase from the 3 million individuals who accessed telehealth during the prior year. The PRAC identified access to telehealth as among the top challenges facing federal agencies in their COVID-19 response efforts in both 2020 and 2021.<sup>1</sup>

We undertook this study to examine the expansion of telehealth across federal programs during the pandemic and, along with this expansion, the emerging risks.

This report summarizes potential program integrity risks identified by the six participating Offices of Inspectors General (OIGs). We wrote this report to inform stakeholders—including Congress; federal and state agencies; and health care organizations—how expanded use of telehealth during the COVID-19 pandemic helped individuals access health care during a crisis, and to raise awareness about the critical importance of safeguarding expanded telehealth services against fraud, waste, and abuse.

Among the key findings across federal health care programs, OIGs identified:

- Dramatic increases in the use of telehealth during the first year of the pandemic.
- A variety of telehealth services that were available to patients.
- Similar program integrity risks that might indicate fraud, waste, or abuse, such as high-volume billing, duplicate claims, and inappropriate charges for the most expensive level of telehealth services.
- A lack of data to assess quality of care and conduct comprehensive oversight of telehealth services.

The selected programs in six agencies include:

1. **Medicare** | Department of Health and Human Services
2. **TRICARE** | Department of Defense
3. **Federal Employees Health Benefits Program** | Office of Personnel Management
4. **Veterans Health Administration** | Department of Veterans Affairs
5. **Office of Workers’ Compensation Programs** | Department of Labor
6. **Federal Bureau of Prisons and U.S. Marshals Service (“DOJ prisoner health care services”)** | Department of Justice

While the selected programs have safeguards in place to monitor telehealth services, additional controls could strengthen program integrity and ensure accurate payments. For example, programs could conduct additional monitoring of telehealth services; enhance efforts to educate providers and individuals about telehealth services; and develop additional billing controls to prevent inappropriate payments.

Taken together, the insights in this report demonstrate the importance of ensuring that the benefits of telehealth are realized across federal health care programs in an effective and efficient manner, while minimizing programmatic and financial risks. Therefore, the PRAC encourages agencies, policymakers, and stakeholders to rely on these insights to inform future decisions on telehealth and to protect against fraud, waste, and abuse.

## About the PRAC

The CARES Act created the PRAC to coordinate oversight of the federal government's pandemic response and historic level of spending. The PRAC's Health Care Subgroup consists of OIGs that oversee the federal agencies that provide or reimburse for health care services. By working together and sharing data, the Health Care Subgroup provides coordinated oversight across agencies and programs.



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# Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic

The COVID-19 pandemic created unprecedented challenges for access to health care in the United States. In response, many federal health care programs took actions to expand access to health care services provided through telehealth. Telehealth services—health care services that are provided remotely using technology between a provider and a patient—allow providers to evaluate and treat patients at home or elsewhere without the added risk of transmitting COVID-19. Providers can also use telehealth to provide critical services when in-person care is not readily accessible, which may be particularly valuable for vulnerable populations.

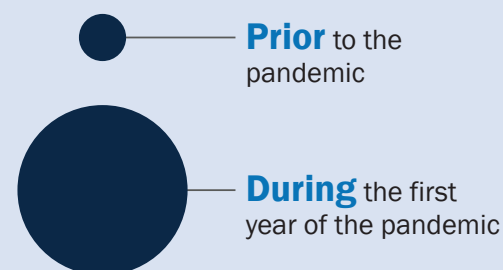
Throughout the pandemic, the use of telehealth has been crucial in ensuring continued access to health care in multiple federal health care programs. As a result, the PRAC Health Care Subgroup has identified the expanded use of telehealth services as critical to the federal COVID-19 response efforts and to the efficiency and economy of those efforts. In addition, while the expansion of telehealth has been essential to maintaining individuals' access to care, there have been concerns about the potential for fraud, waste, and abuse associated with expanded telehealth services.

This report provides policymakers and stakeholders—such as Congress; federal and state agencies; and health care organizations—with information about the nature of telehealth and its use across selected health care programs in six federal agencies during the first year of the pandemic. It also provides insights into the program integrity risks associated with telehealth and safeguards that could strengthen oversight in these programs. These insights can help inform decisions on which telehealth changes should remain after the pandemic and how programs can incorporate appropriate safeguards to protect against fraud, waste, and abuse.

**During the first year of the pandemic**, approximately

**37 million** individuals used telehealth services across the selected programs in six federal agencies,

**13 times** the number of individuals who used telehealth the **prior year**.



Source: Analysis of data from selected federal health care programs, 2022.

## HOW WE CONDUCTED THIS STUDY

The PRAC Health Care Subgroup comprises six Offices of Inspectors General (OIGs) responsible for the oversight of agencies that provide or are involved with the provision of health care services. These agencies are the Department of Health and Human Services (HHS), the Department of Defense (DoD), the Office of Personnel Management (OPM), the Department of Veterans Affairs (VA), the Department of Labor (DOL), and the Department of Justice (DOJ). For this review, the six OIGs selected programs or components within their agencies for which they could obtain data on the use of telehealth during the first year of the pandemic. Throughout this report, we use the term “program” to refer to these programs and components. We also use the term “individual” to represent the beneficiaries or persons served by each of these programs.

The nature of the health care programs selected for review vary. While most of the programs exclusively pay for health care delivered by providers in the community, other programs deliver care directly to individuals and, under certain circumstances, pay for care delivered by providers in the community, among other arrangements.<sup>2</sup> The programs also vary in size and population. See Exhibit 1 for more information about the federal health care programs selected for this report, such as the populations that each serves and the role of each in providing telehealth services.

Each OIG collected data on the nature and use of telehealth in the year prior to the pandemic (March 2019 through February 2020) and during the first year of the pandemic (March 2020 through February 2021) and identified program integrity risks and safeguards associated with telehealth in the selected health care program. The data that the six OIGs collected focused on four questions.

- 1. To what extent did the selected programs in six federal agencies make telehealth services available to individuals during the pandemic?**
- 2. To what extent did individuals served by the selected programs use telehealth services during the first year of the pandemic?**
- 3. What types of program integrity risks are associated with the use of telehealth services?**
- 4. What types of data and safeguards could strengthen oversight?**

The General Methodology section and the more detailed methodologies in the appendices contain additional information on how each OIG conducted its analysis.

**Exhibit 1: Federal health care programs selected for this report and the populations that they serve**

<i>Federal Health Care Program</i>	<i>Population Served</i>	<i>Role of the program in providing telehealth services</i>
<b>HHS</b> Medicare	66 million adults age 65 years and older, as well as those with end-stage renal disease and people with a qualifying disability.	Medicare pays for claims for telehealth services and contracts with Medicare Advantage plans to provide coverage.
<b>DoD</b> TRICARE	3.5 million military personnel and their families enrolled in TRICARE Prime and TRICARE Select.	TRICARE reimburses telehealth providers through a fee-for-service arrangement based on an allowable charge.
<b>OPM</b> Federal Employees Health Benefits Program	8 million federal employees, retirees, and other eligible individuals.	The Federal Employees Health Benefits Program contracts with approximately 80 insurance carriers, otherwise known as insurers, that process and pay for claims for telehealth services.
<b>VA</b> Veterans Health Administration (VHA)	5.6 million enrolled veterans who actively use VA services. <sup>3</sup>	The Veterans Health Administration provides direct patient care, including telehealth. It also reimburses third-party administrators that process claims and pay non-VA providers under the Veterans Community Care Program.
<b>DOL</b> Office of Workers' Compensation Programs	145,000 workers who filed for workers' compensation and received medical benefits, including federal employees who experienced work-related injury or disease; current or former Department of Energy workers and contractors; and former coal miners and their surviving dependents.	Office of Workers' Compensation Programs processes and pays claims for telehealth services.
<b>DOJ</b> DOJ prisoner health care services	179,000 federal prisoners, including those housed in federal prisons (institutions) operated by the Federal Bureau of Prisons and those housed in detention facilities in the custody of the United States Marshals Service. DOJ's United States Marshals Service and the Federal Bureau of Prisons are separate DOJ components with distinct prisoner populations and health care services. Throughout this report, we refer to both components' services collectively as "DOJ prisoner health care services."	122 institutions operated by the Federal Bureau of Prisons provide direct care and pay for external care provided in the community. The United States Marshals Service maintains agreements with over 800 state and local detention facilities and other types of facilities to house prisoners in its custody and relies on these facilities to ensure prisoners receive medical care. It also reimburses its National Managed Care Contract contractor, which processes and pays claims for external care provided to its prisoners.

Source: Analysis of information from selected programs in six federal agencies, 2022.

Notes: Although DoD delivers health care in its military treatment facilities, only telehealth provided by private sector providers was included in this review. DoD also has a program called TRICARE for Life—a type of Medicare wraparound coverage for beneficiaries who have Medicare Parts A and B—that was not included in this review.

A fourth Workers' Compensation program, the Longshore program, is not included in this review.

The Federal Bureau of Prisons is responsible for confining federal prisoners in controlled environments that are safe and secure, and it must also ensure prisoners are housed in humane facilities and receive adequate health care. The United States Marshals Service is responsible for providing safe, secure, and humane custody; housing; medical care; and transportation to prisoners awaiting trial or sentencing decisions.



## TELEHEALTH POLICY

### **INSIGHT: The selected programs in six federal agencies took various steps to make telehealth available during the pandemic**

The selected programs took a variety of actions to help ensure telehealth was available to the individuals they serve during the pandemic. (See Exhibit 2.)

#### **Exhibit 2: Key Actions Taken to Ensure Availability of Telehealth During the First Year of the Pandemic**

**HHS Medicare.** In March 2020, Congress, HHS, and the Centers for Medicare & Medicaid Services (CMS) temporarily expanded access to telehealth in Medicare allowing beneficiaries to use telehealth for a wide range of services in different locations, including in urban areas and from the beneficiary's home. Prior to the pandemic, generally only beneficiaries in rural areas were allowed to use telehealth and they were generally not allowed to use telehealth from home. In addition, beneficiaries were limited to using telehealth for relatively few services.

**DoD TRICARE.** The Defense Health Agency temporarily expanded access to telehealth services and created flexibility for beneficiaries to use telehealth. For example, it temporarily lifted a requirement that patients use full audio and video during telehealth appointments, allowing patients to use audio-only.

**OPM Federal Employees Health Benefits Program.** In response to the pandemic, OPM issued guidance—i.e., Carrier Letters—to the health insurance carriers that provide health benefits, urging the insurers to review their preparedness and take necessary steps to provide services without interruption. OPM also encouraged insurers to consider solutions that waive cost-sharing for telehealth visits associated with the treatment of COVID-19.

**VA Veterans Health Administration.** Beginning in March and April 2020, the Veterans Health Administration took actions to expand its existing telehealth program. For example, modified guidance was issued allowing certain flexibilities related to credentialing and privileging of providers in anticipation of staffing shortages. The Veterans Health Administration also authorized providers to utilize audio or video communication technology for telehealth services. Further, it introduced the “digital divide consult,” where patients are loaned a video-capable device if they lacked such resources.

**DOL Office of Workers' Compensation Programs.** At the start of the pandemic, the Office of Workers' Compensation Programs instituted new policies that expanded access to telehealth for injured workers in its three programs by allowing routine medical care to be provided through telehealth by certain types of medical care practitioners. Prior to the pandemic, only one of its programs—the Federal Employees Compensation Act program—allowed telehealth.

**DOJ prisoner health care services.** The DOJ did not have policies specific to telehealth for prisoners in its custody. A change the DOJ made during the pandemic was that the Federal Bureau of Prisons temporarily waived some timeliness requirements for certain telehealth providers to complete credential verification and privileges and helped streamline the process for approving telehealth providers.



All of the programs issued new policies or guidance to increase access to telehealth, expanding coverage of telehealth services and introducing new flexibilities to enable individuals to receive care via telehealth. In addition, Congress also took legislative action to expand access to telehealth services for beneficiaries in two programs—Medicare and the Veterans Health Administration.

## **INSIGHT: The selected programs in six federal agencies provided relatively similar coverage of telehealth services during the pandemic**

The selected programs provided relatively similar coverage of telehealth services during the first year of the pandemic. The programs covered a range of telehealth services and offered flexibilities related to where and how individuals received telehealth services. There was variation, however, in how programs handled patient cost-sharing and provider payment amounts.

### **All selected programs allowed telehealth to be used for a variety of services**

These services generally included visits with primary care and specialists; behavioral health care; and physical, occupational, and speech therapy.<sup>4</sup> Some programs also covered virtual care services, such as telephone calls with a provider or interactions via an online patient portal, and remote monitoring, such as weight and blood pressure checks. Programs also covered other services. For example, Medicare covered ophthalmology services delivered using telehealth. Prior to the pandemic, Medicare, Workers' Compensation, and the Federal Employees Health Benefits Program covered fewer telehealth services.<sup>5</sup>

In addition, the programs had different ways of determining which services could be provided via telehealth. Two programs—Medicare and Workers' Compensation—issued a specific list of services that could be provided via telehealth. The other programs—the Veterans Health Administration, TRICARE, DOJ prisoner health care services, and the Federal Employees Health Benefits Program—allowed the provider, facility, or health insurers to determine which specific services could be provided via telehealth.

### **All selected programs allowed audio-only telehealth but to varying extents**

All of the programs allowed the individuals they serve to access at least some telehealth services using audio-only during the pandemic.<sup>6</sup> Three of the programs—TRICARE, Medicare, and Workers' Compensation—limited audio-only telehealth to certain services, while the DOJ prisoner health care services and Veterans Health Administration did not limit audio-only telehealth to certain services. The Federal Employees Health Benefits Program coverage varied by insurer, with most insurers allowing audio-only telehealth services.

### **Programs allowed individuals to access telehealth from their homes**

None of the programs required patients to travel to health care settings to receive telehealth services during the pandemic. All programs allowed individuals to receive telehealth in their homes (or from prisons, when available) during the pandemic.

Prior to the pandemic, Medicare generally required beneficiaries to travel to a health care setting, such as a doctor's office or hospital, to use telehealth.<sup>7</sup> Medicare also generally limited telehealth services to beneficiaries in rural areas prior to the pandemic. None of the other programs had similar limitations prior to the pandemic.

### **All selected programs had no cost-sharing for patients or allowed cost-sharing to be waived**

In several programs, individuals had no cost-sharing, such as a copayment or coinsurance, for most or all of their telehealth services during the first year of the pandemic. These programs included TRICARE, the Veterans Health Administration, Workers' Compensation, and DOJ prisoner health care services.<sup>8</sup> Prior to the pandemic, TRICARE and the Veterans Health Administration had cost-sharing for at least some individuals, but the DOJ prisoner health care services and Workers' Compensation did not.<sup>9</sup>

The other two programs—Medicare and the Federal Employees Health Benefits Program—both had cost-sharing for at least some services during the pandemic. The Federal Employees Health Benefits Program encouraged, but did not require, the insurers to waive telehealth cost-sharing associated with the treatment of COVID-19. However, most insurers waived cost-sharing either for all telehealth services or for telehealth services that led to a COVID-19 diagnosis for at least a portion of the first year of the pandemic. Medicare fee-for-service continued to require cost-sharing during the pandemic; however, providers could waive cost-sharing for services provided via telehealth.<sup>10</sup>

### **Four programs paid providers equivalent amounts for telehealth services and in-person services**

Medicare, TRICARE, and Workers' Compensation programs paid providers equivalent amounts for telehealth services and in-person services. Similarly, the Veterans Health Administration paid equivalent amounts for telehealth services and in-person services when paying non-VA providers in the community. This was a change for all of these programs except the Workers' Compensation programs, which paid providers equivalent amounts for these services prior to the pandemic.<sup>11</sup>

DOJ's Federal Bureau of Prisons pays a salary to some providers to care for individuals in its prisons; these providers do not receive a payment per service. Providers employed by the Veterans Health Administration are paid a salary, as opposed to a payment per service. The Federal Employees Health Benefits Program does not set payment rates.

## USE OF TELEHEALTH

### **INSIGHT: All selected programs in six federal agencies experienced dramatic increases in the use of telehealth during the first year of the pandemic compared to the year prior**

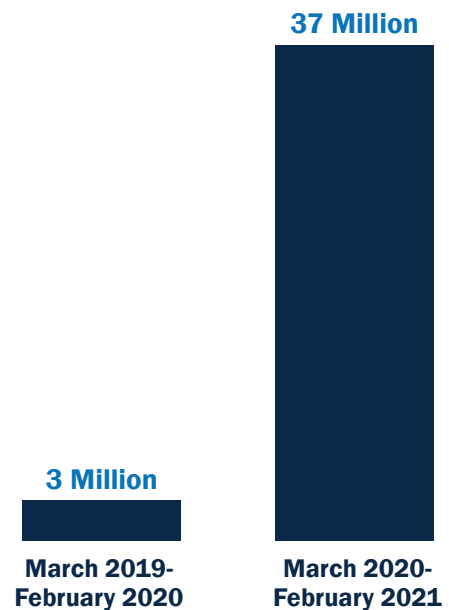
All selected programs had large increases in the use of telehealth during the first year of the COVID-19 pandemic—i.e., from March 2020 through February 2021—compared to the year prior, from March 2019 through February 2020. With limited access to in-person care and many programs expanding flexibilities for the use of telehealth, each program saw a significant uptick in the use of telehealth from the year prior to the pandemic.

### **Approximately 37 million individuals used telehealth in the selected programs during the first year of the pandemic**

In total, approximately 37 million individuals used telehealth services from March 2020 through February 2021 in the selected programs in six federal agencies.<sup>12</sup> This was a dramatic increase from the year prior, when approximately 3 million individuals used telehealth services in these programs. Overall, the number of individuals using telehealth in these programs was 13 times as high in the first year of the pandemic as in the prior year. See Exhibit 3.

Two programs—Medicare and TRICARE—had the largest increases, with over 80 times the number from the prior year in Medicare, and over 70 times the number in TRICARE. During the pandemic, Medicare allowed individuals to use telehealth for a wide range of services in different locations. Prior to the pandemic, generally only Medicare beneficiaries in rural areas could use telehealth services and beneficiaries were generally not allowed to receive telehealth services from home. Similarly, TRICARE expanded coverage for telehealth services during the pandemic, including allowing for audio-only telehealth services and waiving cost-sharing for telehealth services, among other changes. See Exhibit 4.

**Exhibit 3: Across the selected programs, 13 times as many individuals used telehealth services during the first year of the COVID-19 pandemic as in the prior year.**



Source: Analysis of data from selected programs in six federal agencies, 2022.

**Exhibit 4: The number of individuals who used telehealth during the pandemic was 13 times as high as in the year prior in the selected programs.**

	<i>Year prior to the pandemic</i>	<i>First year of the pandemic</i>	<i>Times increase</i>
<b>Medicare</b>	341,000	28 million	83
<b>TRICARE</b>	23,900	1.7 million	71
<b>DOL Workers' Compensation Programs</b>	500	16,000	32
<b>Federal Employees Health Benefits Program</b>	78,900	2.2 million	28
<b>Veterans Health Administration</b>	2.3 million	4.8 million	2
<b>DOJ prisoner health care services</b>	2,065	4,285	2
<b>Total</b>	<b>3 million</b>	<b>37 million</b>	<b>13</b>

Source: Analysis of data from selected programs in six federal agencies, 2022.

Notes: The total represents the aggregated number of individuals who used telehealth in each program. Individuals who received telehealth from more than one program may be counted multiple times. Numbers are rounded. Calculations of totals and increases were conducted on unrounded numbers.

The number of individuals who used telehealth in the Veterans Health Administration includes those who used telehealth directly from VA providers; it does not include data on individuals who received telehealth from non-VA providers in the community. In addition, the numbers for the Federal Employees Health Benefits Program include data from the largest insurer, which represents approximately 68 percent of individuals enrolled in all plans.

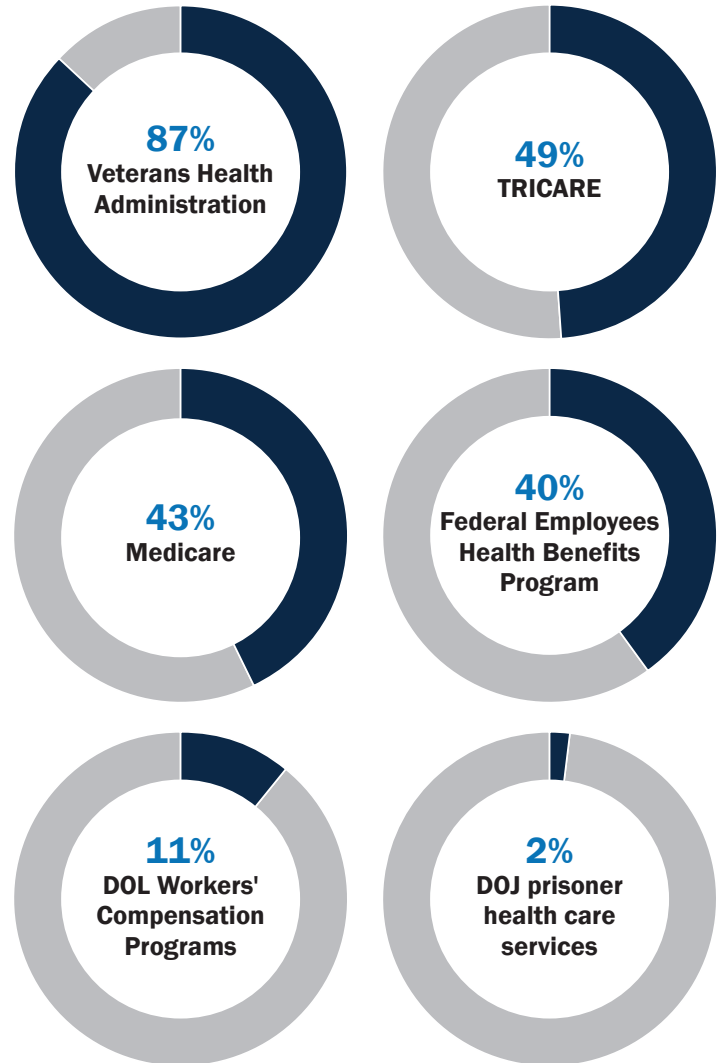
## The percentage of individuals using telehealth varied by program, with the highest percentage at the Veterans Health Administration

Individuals used telehealth to varying degrees during the pandemic in the selected programs. The highest percentage of individuals who used telehealth was in the Veterans Health Administration.<sup>13</sup> Almost 90 percent of veterans served by the program used telehealth during the first year of the pandemic. See Exhibit 5. Compared to the other federal health care programs, the Veterans Health Administration allowed for greater access to telehealth prior to the pandemic and then expanded flexibilities for telehealth even further once the pandemic began. For example, prior to the pandemic, the Veterans Health Administration allowed for both audio-video and audio-only telehealth services and, during the pandemic, built upon a program to lend veterans broadband-enabled devices so they could access telehealth services.

In three other programs, about two in five individuals used telehealth. In these programs—the Federal Employees Health Benefits Program, Medicare, and TRICARE—40 percent to 49 percent of the individuals they served used telehealth during the first year of the pandemic. These three programs had limitations on access to telehealth prior to the pandemic and then expanded access once the pandemic began.

Telehealth was less common in Workers’ Compensation and DOJ prisoner health care services. These programs differ from the others. Workers’ Compensation covers care only for work-related injury. Unlike the other programs, it does not provide comprehensive medical care for the individuals it serves. Further, DOJ prisoners can directly receive in-person care provided by staff working in the facilities in which they are housed.

**Exhibit 5: Percentage of individuals using telehealth in each program.**



Source: Analysis of data from selected programs in six federal agencies, 2022.

Notes: The number of individuals who used telehealth in the Veterans Health Administration includes those who used telehealth directly from VA providers. In addition, the numbers for the Federal Employees Health Benefits Program include data from the largest insurer, which represents approximately 68 percent of individuals enrolled in all plans.

## In total, individuals in the selected programs used about 156 million telehealth services during the first year of the pandemic

Individuals in Medicare used the most telehealth services, totaling 114.4 million services. In contrast, the individuals in the DOJ prisoner health care services used about 6,000 telehealth services during the first year of the pandemic. See Exhibit 6.

### Exhibit 6: Individuals in the selected programs used about 156 million telehealth services during the first year of the pandemic.

<b>Medicare</b>	114.4 million
<b>Veterans Health Administration</b>	27.1 million
<b>Federal Employees Health Benefits Program</b>	8.0 million
<b>TRICARE</b>	5.9 million
<b>DOL Workers' Compensation Programs</b>	58,000
<b>DOJ prisoner health care services</b>	5,900
<b>Total</b>	<b>156 million</b>

Source: Analysis of data from selected programs in six federal agencies, 2022.

Notes: The number of telehealth services used in the Veterans Health Administration includes services provided directly by VA providers; it does not include data on services provided by non-VA providers in the community. In addition, the numbers for the Federal Employees Health Benefits Program include data from the largest insurer, which represents approximately 68 percent of individuals enrolled in all plans.

## Office visits with a primary care provider or specialist and behavioral health services were the most common telehealth services in the selected programs

In most of the programs, office visits with a primary care provider or specialist and behavioral health services (e.g., individual therapy, group therapy, and substance use disorder treatment) accounted for the vast majority of telehealth services used by individuals in the selected programs. For example, office visits and behavioral health services accounted for 93 percent of all telehealth services in Workers' Compensation; these same services accounted for 91 percent of telehealth services in the Federal Employees Health Benefits Program.<sup>14</sup> See Exhibit 7 for the three most common service types by program. Because of differences in data, the service categories vary in some programs.

**Exhibit 7: Top three most common types of telehealth services during the first year of the pandemic in each program**

	<i>First</i>	<i>Second</i>	<i>Third</i>
<b>Medicare</b>	Office visits with primary care or specialists	Virtual care services <sup>15</sup>	Behavioral health services
<b>TRICARE</b>	Primary care	Mental health care	Specialty care
<b>Federal Employees Health Benefits Program</b>	Office visits with primary care or specialists	Behavioral health services	Physical therapy, occupational therapy, and speech therapy
<b>Veterans Health Administration</b>	Primary care	Behavioral health services	Specialty care
<b>DOL Workers' Compensation Programs</b>	Office visits with primary care or specialists	Behavioral health services	Physical therapy, occupational therapy, and speech therapy
<b>DOJ prisoner health care services</b>	Psychiatry	Cardiology	Nephrology

Source: Analysis of data from selected programs in six federal agencies, 2022.

Notes: Because of differences in data and analysis, service categories are not the same across all agencies. For example, some programs combine office visits for primary care and specialty care; others analyze these separately.

The DOJ OIG's analysis includes only services provided in the Federal Bureau of Prisons by specialists and is broken out by specialty of the provider, rather than category of service. In addition, the most common telehealth services in the Veterans Health Administration are based on data on telehealth services provided directly by VA providers.

**The total amount that the selected programs paid for telehealth services exceeded \$6 billion during the first year of the pandemic**

During the first year of the pandemic, the selected programs in six federal agencies spent more than \$6.2 billion on telehealth services. Most of this spending was in Medicare, which accounted for \$5.1 billion. TRICARE and the Federal Employees Health Benefits Program accounted for an additional \$1 billion. See Exhibit 8.

This amount underestimates the total amount spent on telehealth services in these programs because of data limitations in some programs. For example, at the time of this report, payment information was available only for services provided by non-VA providers in the community, not for services provided by VA providers. In addition, payment information is available only for Medicare fee-for-service and not Medicare Advantage, which accounts for just under half of all telehealth services used in Medicare during the first year of the pandemic.



**Exhibit 8: The selected programs paid more than \$6 billion for telehealth services during the first year of the pandemic.**

<b>Medicare</b>	\$5.1 billion
<b>Federal Employees Health Benefits Program</b>	\$646 million
<b>TRICARE</b>	\$394 million
<b>Veterans Health Administration</b>	\$62 million
<b>DOL Workers' Compensation Programs</b>	\$7.3 million
<b>DOJ prisoner health care services</b>	\$444,800
<b>Total</b>	<b>\$6 billion</b>

Source: Analysis of data from selected programs in six federal agencies, 2022.

Notes: The amount spent on telehealth services is an underestimate because of limitations in the data. For example, the amount the Veterans Health Administration spent is only for services that were provided by non-VA providers in the community.

## PROGRAM INTEGRITY

### **INSIGHT: OIGs identified several program integrity risks associated with billing for telehealth services that were similar across multiple programs**

The six OIGs identified risks related to billing and payment for telehealth services in the selected programs. Some of the OIGs also identified specific providers with telehealth billing practices that raise concern and may indicate fraud, waste, or abuse.

### **OIGs identified risks involving inappropriate billing for the highest, most expensive level of telehealth services**

Billing for higher levels of services than medically necessary—or billing for levels of services that were not rendered—to inappropriately increase payment amounts is a scheme that is sometimes called “upcoding.”

Three OIGs—HHS, OPM, and DOL—identified providers who billed for the highest level of telehealth services for a large proportion of their telehealth services. For example, the HHS OIG identified more than 300 Medicare providers who billed for telehealth services at the highest, most expensive level every time, totaling approximately \$5.2 million.

In another example of this type of risk, the DOL OIG identified a provider who treated an individual twice weekly for 45-50 minutes, including phone consultations, but used an inappropriate billing code that represented 60 minutes of psychotherapy.<sup>16</sup> The billing record showed that the provider had consistently used the 60-minute billing codes for most of his cases.

A fourth OIG—VA OIG—identified an increased volume of telehealth claims billed at the high-intensity service level during the first year of the pandemic. The providers who billed these claims were paid approximately \$10.7 million. In addition, the DoD OIG found that TRICARE also identified billing for high levels of service as a potential fraud risk and established a process to identify providers who billed for the highest level of telehealth services for a large proportion of their telehealth services.

#### **Exhibit 9: Examples of program integrity risks associated with billing of telehealth services**

- “Upcoding” telehealth visits by billing for visits longer than they lasted, or providing basic services and then billing for more complex visits
- Duplicate billing of the same service
- Billing for services that were not provided or not medically necessary
- Billing for services that are seemingly not appropriate for telehealth or ineligible for telehealth
- Ordering unnecessary durable medical equipment, supplies, or laboratory tests associated with a telehealth visit

## **OIGs identified risks related to duplicate claims and high-volume billing**

**Duplicate claims** | OIGs identified concerns related to providers billing twice for the same service. Billing in this manner may indicate that providers are intentionally submitting duplicate claims to increase their payments.

Notably, the HHS OIG identified 138 providers who repeatedly billed both Medicare fee-for-service and a Medicare Advantage plan for the same telehealth service. The VA OIG also identified duplicate claims for the same telehealth service in the VA's programs. The VA paid approximately \$1.5 million for about 14,000 possible duplicate telehealth claims involving about 1,900 providers. The DoD OIG also found that TRICARE identified these types of claims as a potential risk.

**High-volume billing** | In addition, OIGs had concerns about high-volume billing, which may indicate that providers are billing for services that are not provided or not necessary. These concerning billing practices, along with duplicate claims and upcoding, also occur with in-person services.

Specifically, three OIGs—HHS, OPM, and VA—identified providers who billed for telehealth services for an unusually high number of hours per visit or per day. For example, the HHS OIG identified 86 providers who billed for a high average number of hours of telehealth services per visit. Additionally, the VA paid approximately \$578,000 for claims (out of a total of about \$62 million spent) that were associated with high usage days—i.e., days on which a provider billed for more than 18 hours of telehealth services—from March 2020 through February 2021. OIGs also identified providers who billed telehealth services for an unusually high number of individuals. The DoD OIG also found that TRICARE identified this type of billing as a potential fraud risk.

## **OIGs identified risks related to billing for services that were seemingly not appropriate for telehealth or ineligible for payment as a telehealth service**

OIGs identified risks related to billing telehealth for inappropriate services. Specifically, the OPM OIG identified one provider who billed wound debridement—the removal of dead or unhealthy skin from a wound—via telehealth, and a different provider who submitted a telehealth claim for anesthesia. The DOL OIG identified a provider who billed for acupuncture via telehealth. Two OIGs—HHS and DoD—also identified providers who billed for telehealth services and facility fees, which would indicate that the patient and provider were in the same location at the time of the telehealth visit. These examples raise concern, as they may indicate that to inappropriately maximize their payments for each visit, providers are billing for services that are not being provided appropriately or billing for telehealth services that never occurred.

## **OIGs also identified risks related to ordering unnecessary durable medical equipment or laboratory tests associated with telehealth visits**

In the last few years, several large health care fraud investigations have involved telemarketing schemes, often referred to as telefraud.<sup>17</sup> In one example, a laboratory owner paid kickbacks to an individual to arrange for telehealth providers to order genetic testing on behalf of Medicare

beneficiaries.<sup>18</sup> This individual then gave Medicare beneficiary information to these providers, which they could use to bill for telehealth services. In some similar cases, the sham telehealth visits were billed to Medicare.<sup>19</sup> In several other cases, the providers did not bill for sham telehealth visits. Instead, the perpetrators billed fraudulently only for other items or services, like durable medical equipment or genetic tests.

In a separate evaluation, the HHS OIG identified 67 providers who, for a large proportion of their Medicare beneficiaries, ordered durable medical equipment after they billed for telehealth visits. This type of billing raises concern that providers may be billing for telehealth services, regardless of whether a beneficiary was ever contacted, and ordering medical equipment and supplies as part of a kickback scheme with suppliers.

The DOL OIG also reported concerns related to billing for durable medical equipment. In one example, the DOL OIG identified a provider who had an uptick in durable medical equipment orders after the provider moved to telehealth, and as a result, this provider accounted for over three-quarters of all spending in the Workers' Compensation programs for one type of durable medical equipment.

## **INSIGHT: OIGs found limited information about the impact of telehealth on quality of care, which has implications for the care provided to individuals and program integrity**

OIGs report that there is limited information about the impact of telehealth on quality of care. Federal health care programs need information on how telehealth affects quality of care to help ensure that individuals served by these programs receive safe and effective health care. Additionally, information on quality of care can help programs make decisions about which services may be best suited for telehealth versus those that are better suited for in-person care. It can also help identify program integrity concerns related to the nature of the care provided, such as whether it is properly supervised or provided by appropriate staff.

Three OIGs—HHS, OPM, and DOJ—found that little is known about quality of care related to telehealth services. The HHS OIG further noted the need to evaluate quality of care, especially as it relates to audio-only telehealth services. The OPM OIG noted that, while OPM does conduct annual quality of care assessments, these assessments do not include any telehealth-specific measures. In addition, just one of the contracted insurers it surveyed indicated that it had a plan to assess quality. The DOJ OIG found that the lack of telehealth policies and robust data on telehealth services could present barriers to the programs' ability to assess quality of care.

Furthermore, the DoD OIG found that TRICARE had limited information about the impact of telehealth services on quality of care. For example, one of two TRICARE contractors included in the DoD OIG's review does not track quality of care issues specific to telehealth. In addition, the VA OIG noted the need for ongoing studies to evaluate the effect of telehealth on quality of care during the COVID-19 pandemic. These studies could evaluate appropriateness of care; admission rates; delay in diagnoses; patient satisfaction; barriers to care; and standardized quality metrics and guidelines.

Despite limited information, OIGs identified some specific concerns related to the impact of telehealth on quality of care. For example, one of TRICARE's contractors identified 89 potential quality issues related to telehealth during the first year of the pandemic, up from seven issues the year before. In the Workers' Compensation programs, providers allegedly rendered services without appropriate supervision, potentially affecting the quality of care provided.

### Example of a concern about quality of care

- The DOL OIG identified a provider who allegedly performed medical evaluations via telehealth using untrained and unsupervised technicians.

## INSIGHT: OIGs found that programs lack some data necessary for oversight of telehealth services

Most OIGs found that the selected programs need additional data to oversee billing for telehealth services and to better understand how telehealth is used in these programs. Complete and reliable data on telehealth services are critical to oversight and protecting against program integrity risks. These data are also important to assessing the impact of telehealth on quality of care.

Notably, the DOJ OIG found that DOJ prisoner health care services lack comprehensive data on telehealth services and, as a result, DOJ is unable to calculate the total cost of telehealth services or determine the total number of telehealth services delivered to prisoners in its custody. For example, DOJ currently lacks a central claims system for the Federal Bureau of Prisons that can track telehealth services and associated costs. This and other limitations affect DOJ's ability to fully assess the use of telehealth for prisoners in federal custody.

### Examples of data needed to oversee telehealth services

- DOJ prisoner health care services lack comprehensive data on telehealth services.
- Medicare lacks data on some providers who render telehealth services.
- DoD's oversight data does not always distinguish telehealth from in-person care.

The HHS OIG found that Medicare lacks specific data on audio-only telehealth services. Medicare can only identify the use of audio-only for six services even though 86 other services can be provided audio-only. This lack of data inhibits HHS's ability to assess the use of audio-only telehealth services on quality of care and program integrity.

The HHS OIG also found that Medicare does not collect data about some of the providers who render services. A billing practice known as "incident to" billing creates challenges for oversight. "Incident to" billing allows for services provided by clinical staff who are directly supervised by a practitioner to be billed under the supervising practitioner's identification number. This lack of transparency prevents HHS from determining which provider rendered a telehealth service to a beneficiary, which is critical to oversight.

The DoD OIG found that TRICARE's oversight data do not always distinguish telehealth services from in-person services, hindering its ability to monitor telehealth. For example, audits of claims

and reports on denials from TRICARE contractors are aggregated to include both in-person and telehealth services, preventing the DoD from analyzing data specific to telehealth services.

The DOL OIG also found instances in which Workers' Compensation data inaccurately identified telehealth services as in-person services, raising concern that telehealth providers may be submitting bills for telehealth services without the appropriate place of service code and/or modifier.

## **INSIGHT: The selected programs in the six federal agencies have some safeguards in place to oversee telehealth services, but additional safeguards could strengthen program integrity**

While all selected programs have processes to oversee telehealth services, there are opportunities to strengthen monitoring and target oversight to ensure program integrity in each program. Doing so will help to realize the benefits of telehealth while minimizing the risk of fraud, waste, and abuse.

### **Program integrity safeguards generally include data analysis, claims edits, medical reviews, and/or audits**

All selected programs have some type of program integrity safeguards in place. Although these safeguards vary by program, they generally include data analysis, claims edits, medical reviews, or audits. These safeguards are similar to safeguards that agencies use to oversee in-person claims and are sometimes specific to telehealth.

All selected programs use data analysis to oversee telehealth. Generally, data analysis identifies concerning billing patterns in claims data. For example, DOJ's United States Marshals Service's National Managed Care Contract contractor for prison medical care has an anti-fraud program that includes identification of unusual patterns of care, over-utilization of services, suspect billing practices, and other unusual patterns using available data. Similarly, the Veterans Health Administration receives reports from its contractors (or third-party administrators) that include information on claims that may be suspicious for telehealth services provided in the community.

Medicare, the Federal Employees Health Benefits Program, TRICARE, and Workers' Compensation also use claims edits and post-payment reviews or audits to safeguard against program integrity risks. Claims edits reject payments for claims that do not meet certain program requirements. Post-payment reviews and audits generally involve a higher level of scrutiny for a sample of claims to ensure that they meet program requirements. For example, Medicare conducts post-payment reviews to determine if billed services were medically necessary. In addition, insurers in the Federal Employees Health Benefits Program typically have edits in place to identify duplicate payments, medical necessity reviews, and upcoding.



#### **OIG Hotlines**

In addition to the programs' efforts, each of the six OIGs operate hotlines where providers and members of the public can report complaints related to health care fraud, waste, and abuse, including those related to telehealth services.



## Additional safeguards could strengthen program integrity for telehealth

OIGs identified several opportunities to strengthen oversight of telehealth services. Although the extent and specific types of additional safeguards that could strengthen each program vary, these safeguards commonly involve monitoring, billing controls, education, and data. A number of OIGs also identified the need for more information related to quality of care. These common safeguards are described below. For information about the specific safeguards needed in each program, see the individual sections.

- » **Programs could conduct additional and ongoing monitoring of telehealth services.** Federal health care programs could conduct additional, targeted monitoring of telehealth services to identify program integrity risks. This monitoring could include data analysis focused on the program integrity risks identified in this report, as well as other risks the programs deem appropriate.

For example, the HHS OIG recommends that Medicare closely monitor telehealth services on an ongoing basis to identify providers who pose a risk to the program and conduct targeted reviews of these providers. These reviews could include close monitoring of providers' billing patterns and reviews of their medical records, as appropriate. These reviews would build on safeguards currently in place and could be used to recover inappropriate payments, place certain providers on pre-payment review, initiate fraud investigations, or develop additional claims processing edits, as necessary.

- » **Programs could develop additional billing controls to prevent inappropriate payments for telehealth services.** Federal health care programs could develop additional billing controls, such as pre-payment edits, to prevent inappropriate payments for telehealth. These controls could address the program integrity risks identified in this report and be tailored to each program, as needed.

For example, the OIGs from both DoD and OPM suggest creating controls to prevent telehealth payments for services that are not appropriate to be delivered using telehealth. The OPM OIG suggests that OPM develop and maintain a list of services for which the Federal Employees Health Benefits Program providers may be reimbursed when performed via telehealth and insurers should be required to place edits in their claims systems that will check telehealth claims against this list. The DoD OIG recommends that TRICARE establish controls to prevent payments for improperly coded telehealth claims, among other controls.

- » **Programs could conduct efforts to educate providers and individuals about telehealth services.** Federal health care programs could conduct additional education for providers and individuals about telehealth services. Such efforts could help ensure that providers know how to correctly bill for telehealth services. These efforts would also help ensure that individuals served by federal health care programs are aware of telehealth policies as well as how to report any suspicious billing to the programs or the OIG hotlines.

For example, the HHS OIG recommends that CMS conduct additional education to providers on appropriate billing for telehealth services. The HHS OIG recommends that CMS target specific providers with high levels of inappropriate billing for telehealth services and provide



them with additional education about the telehealth services inappropriately billed and the Medicare guidelines that should have been followed. Further, the OPM OIG suggests that OPM issue guidance to its Federal Employees Health Benefits Program's carriers and members on telehealth-related concerns.

- » **Programs could collect additional data to support better oversight of telehealth services.** Federal health care programs could collect additional data to improve program integrity efforts related to telehealth services and help safeguard the programs against fraud, waste, and abuse. These additional data could address concerns related to the lack of data identified in this report and other concerns, as appropriate.

For example, to address concerns that DOJ prisoner health care services lacked key data, the DOJ OIG noted that DOJ should strengthen its collection of telehealth data and conduct additional research to safeguard program integrity. Additionally, the HHS OIG recommends that Medicare collect specific data to improve oversight of telehealth, including data on audio-only telehealth services and data to indicate when services are provided "incident to" supervising practitioners. Improving transparency of "incident to" services would strengthen Medicare's program integrity efforts and enable oversight agencies to conduct more detailed monitoring at the provider level.<sup>20</sup> Comprehensive data on telehealth services are critical for safeguarding federal health care programs.

- » **Programs could collect and review information about the impact of telehealth services on quality of care.** Programs could collect and evaluate data on the impact of telehealth services on quality of care. For example, the VA OIG noted that ongoing study is needed on the impact of telehealth on quality of care during the pandemic, such as appropriateness of care, readmission rates, delay in diagnoses, patient satisfaction, barriers to care, standardized quality metrics, and guidelines.

Federal health care programs could then use this information on how telehealth affects quality of care to help ensure that individuals served by these programs receive high-quality care. Additionally, information on quality of care can help programs make decisions about which services may be best suited for telehealth versus those that are better suited for in-person care. Further, this information can protect the integrity of telehealth services provided through these federal programs, as some practices pose concerns for both quality and program integrity. For example, if an unqualified practitioner provides and bills for services via telehealth, individuals may receive substandard care and the programs may be paying inappropriately for those services. Programs could also consider information on quality of care, as well as information about the impact of telehealth on program integrity and access to care, as they consider long-term policies related to telehealth.

# Conclusion

The changes to telehealth policy, along with the dramatic increase in the use of telehealth, during the first year of the COVID-19 pandemic underscore the importance of identifying program integrity risks associated with telehealth services and of identifying ways to safeguard the program against fraud, waste, and abuse.

This report provides insights about the nature of telehealth and its use across selected programs in six federal agencies during the first year of the pandemic, as well as insights about the program integrity risks associated with telehealth and safeguards that could strengthen oversight. Although this report does not represent a comprehensive review of telehealth services in all federal health care programs, it provides insights on the populations covered by a variety of federal health care programs.

The insights summarized below are intended to help stakeholders—such as Congress; federal and state agencies; and health care organizations—understand how the expanded use of telehealth during the COVID-19 pandemic helped individuals access health care when there were challenges to accessing care in person and how best to use telehealth in the future while safeguarding against fraud, waste, and abuse.

- The selected programs in six federal agencies took various steps—including issuing new policies and guidance—to make telehealth available during the pandemic.
- The selected programs provided relatively similar coverage of telehealth services during the pandemic, including covering a range of telehealth services.
- All of the selected programs experienced dramatic increases in the use of telehealth during the first year of the pandemic.
- OIGs identified several program integrity risks associated with billing for telehealth services that were similar across multiple health care programs, such as risks involving inappropriate billing for the highest, most expensive level of telehealth services and risks related to duplicate claims and high-volume billing.
- OIGs found limited information about the impact of telehealth on quality of care.
- OIGs found that programs lack some data necessary for oversight of telehealth services.

- The selected health care programs have some safeguards in place to oversee telehealth services, but additional safeguards could strengthen program integrity. For example:
  - » **Programs could conduct additional monitoring of telehealth services.**
  - » **Programs could develop additional billing controls to prevent inappropriate payments for telehealth services.**
  - » **Programs could conduct efforts to educate providers and individuals about telehealth services.**
  - » **Programs could collect additional data related to telehealth services.**
  - » **Programs could collect and review information about the impact of telehealth services on quality of care.**

These insights demonstrate the importance of ensuring the benefits of telehealth are realized while minimizing the risk in an effective and efficient manner.

## GENERAL METHODOLOGY

The PRAC Health Care Subgroup consists of six OIGs that oversee agencies that provide or are involved with the provision of health care services. These agencies are HHS, OPM, DOL, VA, DoD, and DOJ. Each of the six OIGs selected a health care program within its agency for which it could obtain reasonably reliable data on the use of telehealth services for the first year of the COVID-19 pandemic, from March 1, 2020, to February 28, 2021, as well as the year prior to the pandemic, from March 1, 2019, to February 29, 2020.

### Data Collection and Analysis

Each OIG collected and analyzed data and information from its selected health care program. The data that the OIGs collected addressed the following topics:

1. To what extent did the selected programs in six federal agencies make telehealth services available to individuals during the pandemic?
2. To what extent did individuals served by these selected programs use telehealth services during the first year of the pandemic?
3. What types of program integrity risks are associated with the use of telehealth services?
4. What types of data and safeguards could strengthen oversight?

**Data collection |** Because the selected health care programs vary, OIGs relied on different sources of information to collect the necessary data. OIGs collected data about telehealth policies, telehealth use, and related program integrity risks using claims and other health care encounter data; using surveys; and reviewing federal statutes, agency guidance, and policy manuals, among other sources.

To ensure a level of standardization and consistency, the HHS OIG, in collaboration with the other participating OIGs and the PRAC, developed a framework to guide data collection and analysis. Each OIG determined which data sources to use in its analyses and coordinated as necessary with officials from its federal health care program to obtain this data. For the program integrity section of the report, the OIGs focused on issues related to billing and payment risks; quality of care; data; and safeguards.<sup>21</sup>

**Data analysis |** Each OIG analyzed telehealth data for its selected health care program and determined key information about the use of telehealth and related program integrity risks. The HHS OIG then reviewed the findings from all selected health care programs to provide broader insights and shared the insights with the other OIGs for review. For agency-specific details about the data and analysis, refer to the methodology section in the appendix.

## Data availability for each of the selected health care programs

**Medicare** | Medicare information included in this review is based on data on telehealth services provided by physicians and non-physician practitioners for all Medicare beneficiaries in Medicare fee-for-service and Medicare Advantage. While information about the use of telehealth is available for all beneficiaries, payment information is not available for beneficiaries enrolled in Medicare Advantage.

**TRICARE** | TRICARE information included in this review is based on data for all TRICARE beneficiaries who are enrolled in TRICARE Prime and TRICARE Select plans in the continental United States. There is another TRICARE Program, called TRICARE for Life—which is Medicare wraparound coverage for beneficiaries who have Medicare Parts A and B—that was not included in this review. In addition, many TRICARE participants obtain telehealth services through Military Treatment Facilities, which were not part of this review.

**Federal Employees Health Benefits Program** | The Federal Employees Health Benefits Program information included in this review is primarily based on Federal Employees Health Benefits Program policies, as well as survey responses from 10 selected Federal Employees Health Benefits Program insurance carriers. Information about the use of telehealth in the Federal Employees Health Benefits Program is based on data from the Federal Employees Health Benefits Program's largest insurance carrier, which operates nationwide and accounts for approximately 68 percent of all individuals enrolled in the Federal Employees Health Benefits Program.

**Veterans Health Administration** | The Veterans Health Administration provides direct care, including telehealth services, to enrolled veterans. The Veterans Health Administration also reimburses third-party administrators that process claims and pay non-VA providers under the Veterans Community Care Program. Data for both programs are included in this review.

**Office of Workers' Compensation Programs** | Workers' Compensation information included in this review is based on data for individuals in the Federal Employees Compensation Act program, the Black Lung program, and the Energy program. A fourth Workers' Compensation program, the Longshore program, is not included in this review.

**DOJ prisoner health care services** | Federal prisoner program information included in this review is based on data for individuals in the Department of Justice's Federal Bureau of Prisons and individuals in the custody of the United States Marshals Service. The data about the types of services used via telehealth and the payment data for the Federal Bureau of Prisons are incomplete because of data limitations. Data from the United States Marshals Service are also incomplete and include only information from its National Managed Care Contract contractor for prisoner medical care.

## LIMITATIONS

This report does not present a comprehensive review of the use of telehealth across all health care programs either provided through or administered by the Federal Government. The data and insights are limited to the selected federal health care programs. There are other federal; state; local; and private providers and payors of telehealth services. Some individuals within the selected federal health care programs may have received telehealth services through one of these alternative sources. Further, some individuals may be enrolled in more than one of the selected federal health care programs and could have received telehealth services from multiple programs.

In addition, this report was designed to identify program integrity risks. None of the examples of risk identified in this report confirm that a particular provider is engaging in fraudulent or abusive practices. Any determination of fraud or an overpayment would require additional investigation.

For agency-specific limitations, see each OIG's detailed methodology in the corresponding appendix.

## STANDARDS

Each OIG conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency (CIGIE). Each OIG followed its own processes to ensure that its contributions to this report met CIGIE standards and provided an attestation to the PRAC stating that it met those standards.

## GLOSSARY

**Audio-only service:** A telehealth service that is provided using a two-way, real-time audio connection that does not include video.

**Audio-video service:** A telehealth service that is provided using a two-way, real-time audio and video connection.

**Behavioral health services:** Health care services to diagnose, evaluate, or treat mental health or substance use disorders.

**Cost-sharing:** The out-of-pocket costs for a covered service that the individual is responsible for paying. Cost-sharing usually includes deductibles, coinsurance, copayments, or similar charges.

**Durable medical equipment:** Equipment and supplies ordered by a health care provider for everyday or extended use. Examples include oxygen equipment, wheelchairs, crutches, or blood testing strips for people with diabetes.

**Edits:** Automated checks coded into a claims processing system that are designed to verify that health insurance claims are coded correctly or to flag the claim for further review.

**Facility fee:** A fee billed by a facility—such as a hospital or physician’s office—for hosting a patient during a telehealth service that is provided by a practitioner who is at a separate location. Also referred to as an “originating site facility fee.”

**Fee-for-service:** A reimbursement method in which doctors and other health care providers are paid for each service performed.

**“Incident to” billing:** A Medicare billing practice that allows for services provided by clinical staff who are directly supervised by a physician or non-physician practitioner to be billed under the supervising practitioner’s identification number.

**Insurance carriers:** A carrier is another name for insurance company. The terms insurer, carrier, and insurance company are generally used interchangeably, and describe a voluntary association or organization that is lawfully engaged in providing, delivering, paying for, or reimbursing the cost of health care services under contracts providing a plan of health insurance, health benefits, or health services.

**Modifier:** Two-digit numbers, characters, or alpha-numeric combinations that provide additional information on a claim. For example, some modifiers are used to identify telehealth services.

**Office visit:** An appointment with a primary care provider or specialist, usually for the evaluation or management of a patient’s health.

**Place of service code:** Two-digit codes on health care claims to indicate the setting in which a service was provided.



**Remote patient monitoring:** Non-face-to-face monitoring and analysis of physiologic factors to understand a patient's health status—for example, remote monitoring of oxygen saturation levels, blood pressure, and weight. Also known as remote physiologic monitoring.

**Telefraud:** Telemarketing schemes that generally involve a phone call or other remote interaction with a patient to order or prescribe medically unnecessary testing, equipment, or prescriptions but do not involve billing for a telehealth service.

**Telehealth company:** A company that employs practitioners to provide on-demand telehealth services to patients. Unlike other providers, telehealth companies do not offer in-person services.

**Telehealth service:** A health care service that is provided remotely using technology between a provider and a patient. This report focuses on the use of telehealth between a patient and a provider; it does not include provider-to-provider interactions.

**Upcoding:** Billing for a health care service at a higher level of complexity or duration than was provided or needed.

**Virtual care services:** A type of telehealth service that is always provided remotely, unlike other types of services that can also be provided in-person. Examples of virtual care services include telephone calls with a provider or interactions via an online patient portal, and remote monitoring, such as weight and blood pressure checks.

# Department of Health and Human Services

# Medicare



HHS's Centers for Medicare & Medicaid Services (CMS) administers the Medicare program, which provides health care coverage for about 66 million beneficiaries who are age 65 or older, are disabled, or have end-stage renal disease. Medicare covers inpatient and outpatient services—e.g., hospital and physician services—for enrolled patients.

Beneficiaries may enroll in Medicare fee-for-service or Medicare Advantage. CMS sets payment rates for services provided in Medicare fee-for-service. To bill Medicare fee-for-service, providers must meet certain requirements, such as having the appropriate licensure, and be enrolled in the program. Beneficiaries enrolled in Medicare fee-for-service are generally responsible for 20 percent of the payment rates. Medicare Advantage plans are offered by private companies and have the flexibility to create provider networks and offer extra benefits, including additional telehealth services.

**Scope of HHS Review:** This review describes Medicare telehealth services provided by physicians and non-physician practitioners.<sup>22</sup> Medicare telehealth services refer to services that are provided remotely using technology between a provider and a beneficiary.<sup>23</sup> This review includes data on telehealth services used by beneficiaries enrolled in Medicare fee-for-service and Medicare Advantage during the first year of the pandemic (from March 2020 through February 2021) and the year prior (from March 2019 through February 2020). See Appendix A for HHS OIG's methodology.













## MEDICARE TELEHEALTH POLICY CHANGES DURING THE PANDEMIC

In March 2020, Congress, HHS, and CMS took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries.<sup>24</sup> These actions allowed Medicare beneficiaries to use telehealth for a wide range of services. In addition, the actions also temporarily lifted restrictions on where Medicare beneficiaries could receive telehealth and changed the payment rates to providers. (See Exhibit 1 below for key policy changes during the pandemic.)<sup>25</sup>

**Services:** Beginning in March 2020, CMS temporarily expanded the types of services that Medicare beneficiaries could receive via telehealth, increasing the number from 118 to 264. These included services such as office visits; behavioral health services; nursing home visits; and physical, occupational, and speech therapy.

CMS also allowed certain services to be provided audio-only, rather than requiring audio-video. These services include office visits and behavioral health services, among others. Prior to the pandemic, audio-video was required for the delivery of almost all telehealth services.<sup>26</sup>

**Exhibit 1: Key Differences in Medicare Telehealth Services Prior to and During the COVID-19 Pandemic**

Prior to the Pandemic	During the Pandemic
 <p>Patients could receive <b>118 types of services</b> via telehealth.</p>	 <p>Patients could receive <b>264 types of services</b> via telehealth.</p>
 <p>Under most circumstances <b>audio-video was required</b>.</p>	 <p>Patients could receive many telehealth services using <b>either audio-video or audio-only</b>.</p>
 <p>Most patients were limited to receiving telehealth at health care <b>facilities in rural areas</b>.</p>	 <p>Patients could receive telehealth from <b>home</b> and in both <b>urban and rural areas</b>.</p>
 <p>Providers were generally <b>paid less</b> than in-person services.</p>	 <p>Providers were generally <b>paid the same rate</b> as in-person services.</p>
 <p><b>Only certain providers</b> could provide telehealth.</p>	 <p><b>Any provider</b> could provide telehealth.</p>
 <p>For certain services, providers could provide telehealth services only to patients with whom they had an <b>established relationship</b>.</p>	 <p>For certain services that were limited to established patients prior to the pandemic, providers could also provide them to <b>new patients</b>.</p>

Source: HHS OIG review of CMS policy, 2022.

**Patients and Providers:** During the pandemic, Medicare beneficiaries could access telehealth services regardless of their geographic location.<sup>27</sup> In addition, beneficiaries were allowed to receive telehealth services from any setting, including from home. Prior to the pandemic, Medicare beneficiaries could in most cases use telehealth from only certain medical facilities located in rural areas, such as rural health clinics.

During the pandemic, CMS also allowed any physician or non-physician practitioner who is eligible to bill Medicare for services to provide telehealth services. Prior to the pandemic, only certain types of practitioners were allowed to bill for telehealth services.

Providers were also permitted to provide telehealth to new patients, in addition to existing patients. For certain services prior to the pandemic, providers could only provide telehealth services to patients with whom they had an established relationship.

**Payment Rates:** CMS also changed payment rates for many telehealth services during the pandemic, making them the same as payment rates for in-person services. Prior to the pandemic, telehealth services were generally paid at lower rates than in-person services.

Patient cost-sharing for telehealth did not change during the pandemic. They were responsible for 20 percent of the payment rates, the same rate as prior to the pandemic.<sup>28</sup>

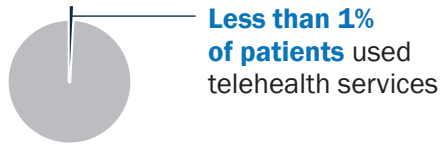
## TELEHEALTH USE DURING THE PANDEMIC

### **During the first year of the pandemic, over 28 million Medicare beneficiaries used telehealth services**

During the first year of the pandemic—i.e., from March 2020 through February 2021—more than 28 million Medicare beneficiaries used a telehealth service.<sup>29</sup> These beneficiaries represented 43 percent of the 66 million beneficiaries enrolled in Medicare, or about 2 in 5 Medicare beneficiaries. This is a dramatic increase from the prior year, when less than 1 percent of Medicare beneficiaries—approximately 341,000 in total—used telehealth. See Exhibit 2.

## Exhibit 2: Key Differences in Beneficiary Use of Medicare Telehealth Services Prior to and During the COVID-19 Pandemic

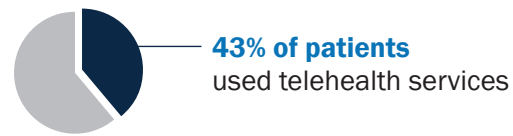
### Prior (March 2019 – February 2020)



Patients received **1.3 million services** via telehealth

Medicare paid over **\$66.4 million** for telehealth services for patients enrolled in Medicare fee-for-service

### During (March 2020 – February 2021)



Patients received **114.4 million services** via telehealth

Medicare paid over **\$5.1 billion** for telehealth services for patients enrolled in Medicare fee-for-service

Source: HHS OIG analysis of Medicare data, 2022.

## Beneficiaries used 88 times more telehealth services during this time period than they used in the prior year

In total, Medicare beneficiaries used 114.4 million telehealth services during the first year of the pandemic, i.e., from March 2020 through February 2021. This amounts to 88 times more telehealth services than the prior year.

About half of these telehealth services (60.1 million in total) were used by beneficiaries enrolled in Medicare fee-for-service. In total, Medicare paid over \$5.1 billion for telehealth services for beneficiaries enrolled in Medicare fee-for-service, 76 times more than what it paid in the year prior.<sup>30</sup>

## Medicare beneficiaries most commonly used telehealth for office visits, virtual care services, and behavioral health services

Together, these three service types accounted for 90 percent of all telehealth services during the first year of the pandemic. Office visits—routine appointments with primary care providers or specialists—accounted for 48 percent of all telehealth services. Virtual care



**Almost half** of all telehealth services were office visits, which are routine appointments with a **primary care provider or specialist**.

Source: HHS OIG analysis of Medicare data, 2022.

services, such as telephone calls with a provider or interactions via an online patient portal, accounted for 30 percent of all telehealth services. Behavioral health services accounted for about 12 percent of all telehealth services. Behavioral health services include individual therapy, group therapy, and substance use disorder treatment, among others. Other types of telehealth services included nursing home visits; preventive services; and physical, occupational, and speech therapy.

### **Most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship**

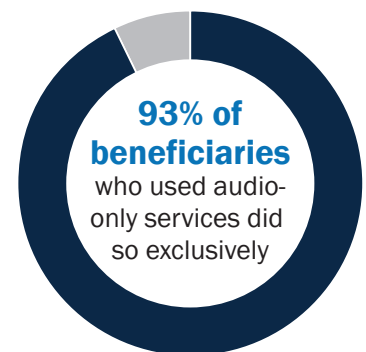
In total, 84 percent of beneficiaries received all their telehealth services during the pandemic from providers with whom they had an established relationship.<sup>31</sup> These beneficiaries had an in-person visit with their provider an average of 4 months prior to their telehealth service. Prior to the pandemic, Medicare required an established relationship between a beneficiary and provider for certain telehealth services.

### **At least 12 million Medicare beneficiaries used audio-only telehealth services; the vast majority of these beneficiaries used them exclusively**

During the first year of the pandemic, a total of 12.7 million Medicare beneficiaries, or 19 percent of all beneficiaries, used one of six telehealth services available only via telephone.<sup>32</sup> These six audio-only services include telephone calls with a provider to discuss a beneficiary’s medical condition. The vast majority of these beneficiaries did not use any audio-video telehealth services, which may suggest that they have a preference for audio-only telehealth services or, that they face barriers to using audio-video telehealth. See Exhibit 3.

It is important to note that an additional 86 telehealth services are available either as audio-only or audio-video, but Medicare data do not distinguish between the two.<sup>33</sup> Therefore, the total number of beneficiaries who used any audio-only services during the first year of the pandemic is higher than 12.7 million.

**Exhibit 3: Most beneficiaries who used audio-only services did not use any audio-video telehealth services**



Source: HHS OIG analysis of Medicare data, 2022.

## PROGRAM INTEGRITY RISKS RELATED TO TELEHEALTH SERVICES

The changes to Medicare telehealth policy, along with the dramatic increase in the use of telehealth, underscore the importance of determining whether providers are billing for telehealth services appropriately and of identifying ways to safeguard the program and ensure quality of care.

This section highlights program integrity risks related to billing, quality of care, and data, as well as needed safeguards for telehealth services.<sup>34</sup> We focus on different types of billing that providers may use to inappropriately bill for telehealth services and that shed light on potential methods specific to telehealth for safeguarding the program and protecting beneficiaries.

### Program Integrity Risks Related to Billing

#### **Data analyses provide insight into different types of billing for telehealth services that may indicate fraud, waste, or abuse and identifies providers whose billing poses a high risk to Medicare**

HHS OIG data analyses of Medicare telehealth services shed light on different types of billing that providers may use to inappropriately maximize their Medicare payments for telehealth services.<sup>35</sup> With input from OIG investigators, we developed seven measures to identify providers whose billing may indicate fraud, waste, or abuse.<sup>36</sup> See Exhibit 4 for a list of these measures.

Using these measures, we identified over 1,700 providers whose billing for telehealth services poses a high risk to Medicare. Although these providers represent a small proportion of the approximately 742,000 providers who billed for a telehealth service, their billing raises concern. For example, some providers billed telehealth services at the highest, most expensive level every time. In these cases, providers may be delivering higher levels of services than medically necessary or billing for levels of services that were not rendered—a scheme that is sometimes called “upcoding.” In other cases, providers billed for telehealth services for a high

#### **Exhibit 4: Program Integrity Measures**

To identify telehealth providers whose billing for telehealth services poses a high risk to Medicare, the HHS OIG developed seven measures based on analysis and input from OIG investigators:

- billing telehealth services at the **highest, most expensive level** every time;
- billing telehealth services for a **high number of days** in a year;
- billing a **high average number of hours** of telehealth services per visit;
- billing telehealth services for a **high number of beneficiaries**;
- billing for a telehealth service and **ordering medical equipment** for a high proportion of beneficiaries;
- billing both **Medicare fee-for-service and a Medicare Advantage plan for the same service** for a high proportion of services; and
- billing both a **telehealth service and a facility fee** for most visits.

Source: HHS OIG analysis of Medicare data, 2022.



number of days a year. Billing in this manner may indicate that the provider is billing for services that were not provided.

## Hotline complaints described similar billing schemes

The HHS OIG operates a hotline where providers and members of the public can report complaints related to health care fraud, waste, and abuse, including those related to telehealth services. Complaints related to telehealth describe similar concerns to those discussed above, such as complaints about services not rendered and services provided that were not medically necessary. See Exhibit 5.

## Investigations raise concerns about kickback schemes involving telehealth

In the last few years, the HHS OIG has conducted several large investigations that involved telemarketing schemes, referred to as telefraud.<sup>37</sup> In many cases, the criminals did not bill for sham telehealth visits. Instead, the perpetrators billed fraudulently for other items or services, like durable medical equipment or genetic tests. In a small number of these cases, the sham telehealth visits were billed to Medicare. In one example, a laboratory owner paid kickbacks to an individual to arrange for telehealth providers to order genetic testing on behalf of Medicare beneficiaries.<sup>38</sup> This individual then gave Medicare beneficiary information to these providers, which they could use to bill for telehealth services. In other cases, telehealth company executives allegedly paid providers to order medically unnecessary durable medical equipment.<sup>39</sup> In some instances, the providers allegedly billed Medicare for telehealth services that did not occur.

### Exhibit 5: Examples of complaints received specific to telehealth include:

- providers instructing staff to “cold call” beneficiaries via telephone and bill for a telehealth visit;
- “upcoding” telehealth visits by billing for visits longer than they lasted, or providing basic services and then billing for more complex visits;
- billing for services not rendered to the patient
- ordering unnecessary equipment, supplies, or lab tests after a telehealth visit;
- billing for services that were not medically necessary; and
- telehealth companies misusing former employees’ information to order items and services.

Source: HHS OIG analysis of OIG hotline complaints data, 2022.

## Quality of Care and Patient Safety

### Little is known about the impact of telehealth on quality of care in Medicare

A recent HHS OIG report indicated the need to evaluate the impact of telehealth and audio-only services on quality of care in Medicare.<sup>40</sup> Knowing the services and populations for which telehealth works best is critical to help stakeholders make decisions about the use of telehealth and audio-only services in the future. See Exhibit 6 for one study about the impact of telehealth on quality of care.<sup>41</sup> Additionally, another study of Medicare fee-for-service beneficiaries found that receiving telehealth services related to opioid use disorder was associated with improved treatment retention and decreased odds of an overdose.<sup>42</sup> Other HHS OIG work found limited information is available on the impact of telehealth on quality of care in Medicaid.<sup>43</sup>

#### Exhibit 6: A recent analysis shed light on the impact of telehealth on Medicare hospital readmissions

One study looked at hospital readmission rates for beneficiaries who received telehealth services following their hospital visits. The study had mixed results, showing that telehealth follow-up visits led to slightly worse outcomes than in-person follow-up visits, but far better outcomes than no follow-up visits.

Source: CMS, *Cares Act Telehealth Expansion: Trends in Post-Discharge Follow-Up and Association with 30-Day Readmissions for Hospital Readmissions Reduction Program Health Conditions*, January 2022.

### Additional Data Needed for Oversight

#### Additional information is needed in Medicare data to improve oversight of telehealth services

Improving the Medicare data is critical to monitoring the program and identifying providers with concerning billing for telehealth services. These data can also be used to better understand the use of telehealth and how it may impact quality of care. Recent HHS OIG reports revealed specific vulnerabilities in the Medicare billing data that are important to the oversight of telehealth services.

First, CMS lacks comprehensive data on audio-only telehealth services. CMS billing data distinguishes between audio-only and audio-video use for only a limited number of telehealth services.<sup>44</sup> This lack of data inhibits CMS's ability to identify all telehealth services provided audio-only, as well as its ability to assess the use of audio-only telehealth services and their impact on quality of care and program integrity.

Second, a Medicare billing practice—known as “incident to” billing—creates challenges for oversight. This practice allows services provided by clinical staff who are directly supervised by a physician or non-physician practitioner to be billed under the supervising practitioner's identification number. This lack of transparency prevents CMS and oversight agencies from determining which provider rendered a telehealth service to a beneficiary, which is critical to oversight.<sup>45</sup>

Third, there is no systematic way to identify telehealth companies in the Medicare data.<sup>46</sup> This

information is important to more closely monitor these companies and to improve oversight of telehealth services.

Fourth, not all types of Medicare providers are required to report when services are provided via telehealth. Importantly, opioid treatment programs—which provide treatment for opioid use disorder—do not submit information about all services that are provided via telehealth.<sup>47</sup> This information is critical to improving the monitoring of telehealth services and to assessing their impact on the quality of treatment services.

## Current Program Integrity Safeguards

To address program integrity risks related to telehealth, CMS uses existing tools such as pre- and post-payment edits and Fraud Prevention System edits.<sup>48</sup> Additionally, CMS is part of the Healthcare Fraud Prevention Partnership and meets with OIG investigators and the Department of Justice (DOJ) to discuss fraud trends and coordinate on certain cases of suspected fraud.<sup>49</sup> CMS also conducts provider interviews, beneficiary interviews, and medical reviews to determine if services billed were medically necessary. For example, one CMS contractor is currently conducting medical reviews of Medicare fee-for-service telehealth services and audio-only services that were billed during the pandemic.<sup>50</sup> When appropriate, CMS can also take actions such as payment suspension, revocation request, overpayment demand, or referral to law enforcement.

## NEEDED PROGRAM INTEGRITY SAFEGUARDS

OIG data analyses and the concerns raised in these reports underscore the need for additional evaluation of the impact of telehealth on quality of care. They also demonstrate the need for strengthening targeted oversight of telehealth services.

To improve program integrity for Medicare telehealth services, in recent reports the HHS OIG has recommended that CMS take the following specific actions:

- » **strengthen monitoring and targeted oversight of telehealth services;**
- » **provide additional education to providers on appropriate billing for telehealth services;**
- » **improve the transparency of “incident to” services when clinical staff primarily delivered a telehealth service;**
- » **identify telehealth companies that bill Medicare;**
- » **require a modifier to identify all audio-only telehealth services provided in Medicare; and**
- » **collect data on the use of telehealth in opioid treatment programs.**<sup>51</sup>



The Defense Health Agency (DHA) administers the TRICARE private sector health benefit, which is part of the DoD's managed health care program. TRICARE provides health care services to approximately 9.6 million active duty, retired, National Guard, and Reserve members, their families, survivors, and qualified beneficiaries.

According to the TRICARE Policy Manual, TRICARE consists of three health care plan options: TRICARE Prime, TRICARE Select, and TRICARE For Life.<sup>52</sup> TRICARE Prime beneficiaries use military treatment facilities and designated civilian provider networks. TRICARE Select beneficiaries use the civilian provider network, but they can also use military treatment facilities when space is available. TRICARE for Life is Medicare wraparound coverage for beneficiaries who have Medicare Parts A and B.<sup>53</sup>

TRICARE reimburses providers for telehealth services through a fee-for-service arrangement based on an allowable charge.<sup>54</sup> The allowable charge is the maximum amount TRICARE will authorize for health services. TRICARE bases the allowable charge on Medicare reimbursement methodologies. To bill TRICARE, health care providers must meet certain requirements, such as appropriate licensure and authorization, and deliver medically necessary services.<sup>55</sup>

**Scope of DoD Review:** This review describes the types of telehealth services offered through the DoD TRICARE Program. We focused on TRICARE Prime and TRICARE Select telehealth claims serviced by two managed support services contractors, which administer the preferred provider network in the continental United States.<sup>56</sup> The DHA defines telehealth as the use of information and telecommunications technology to provide medically and psychologically necessary and appropriate diagnostic and treatment services across distances. Our review includes data on private sector telehealth services from the first year of the COVID-19 pandemic, March 2020–February 2021, and the prior year, March 2019–February 2020 (see Appendix B for DoD OIG's methodology).

## TRICARE TELEHEALTH POLICY CHANGES DURING THE PANDEMIC

Due to the COVID-19 pandemic, in May 2020, the DHA issued an interim final rule to expand temporary access for TRICARE telehealth services.<sup>57</sup> Specifically, the DHA created flexibility for beneficiaries to use telehealth. For example, the DHA temporarily lifted a requirement that patients use full audio and video during telehealth appointments, allowing patients to use audio only. The DHA also waived copayments for telehealth services.<sup>58</sup> (See Exhibit 1 for key policy changes during the pandemic.)

**Services:** Prior to the COVID-19 pandemic, the TRICARE Operations Manual required providers to implement telehealth services to the greatest extent practical. The DHA officials reported that there is not a specific authorized list of services, which providers can deliver through telehealth.

**Patients and Providers:** During the COVID-19 pandemic, TRICARE beneficiaries could access telehealth services by using video teleconferencing or audio only (telephone). Prior to the COVID-19 pandemic, TRICARE beneficiaries could receive audio-only telehealth services only under limited circumstances. The DHA officials also reported that they added TRICARE coverage for remote monitoring of acute and chronic conditions during the pandemic. Prior to the COVID-19 pandemic, the DHA did not allow coverage of remote physiologic monitoring for acute and chronic conditions. The DHA officials reported that they authorized an exception to policy for telehealth capabilities covering applied behavioral analysis services, such as unlimited use of family adaptive behavior treatment. Prior to the COVID-19 pandemic, the DHA did not authorize unlimited use of family adaptive behavior treatment. The DHA issued guidance that authorized temporary telehealth care support for applied behavior analysis. This guidance applied to parents or caregivers' services covering children with autism.

During the COVID-19 pandemic, the DHA authorized reimbursement for interstate practice even if the provider did not have a license in the state where the patient is located, covering states that had in-state licensure-waivers as part of their pandemic response. Prior to the COVID-19 pandemic, TRICARE did not reimburse telehealth service providers who did not have a license in the state where the patient is located.

**Payment Rates:** During the COVID-19 pandemic, DHA authorized providers to receive reimbursement of an equivalent amount as if the providers rendered the service in person. Prior to the pandemic, providers did not receive reimbursement of an equivalent amount as if the provider rendered the telehealth service in person.

In May 2020, the DHA waived beneficiary copayments and cost-sharing, including deductibles, for telehealth services. Prior to the COVID-19 pandemic, beneficiaries were responsible for copayments and cost-sharing, including deductibles.

**Exhibit 1: Key Differences in TRICARE Telehealth Services Prior to and During the COVID-19 Pandemic**

**Prior to the Pandemic**

**During the Pandemic**



Under most circumstances, **audio-video was required.**



Patients could receive many telehealth services using **either audio-video or audio-only.**



**Beneficiaries were responsible for copayments and cost-sharing** (including deductibles).



The DHA **waived beneficiary obligations for copayments and cost-sharing** (including deductibles).



TRICARE **did not authorize reimbursement for interstate practice** if the provider did not have a license in the state where the patient is located.



TRICARE **authorized reimbursement for interstate practice** even if the provider did not have a license in the state where the patient is located.



The DHA **did not authorize providers to receive** reimbursement of **an equivalent amount** as if the telehealth service was rendered in person.



The DHA **authorized providers to receive** reimbursement of **an equivalent amount** as if the service was rendered in person.



The DHA **did not allow coverage of remote physiologic monitoring** for acute and chronic conditions.



The DHA **added TRICARE coverage for remote physiologic monitoring** of acute and chronic conditions. Remote physiologic monitoring includes services such as weight, blood pressure, and pulse checks.



The DHA **did not authorize unlimited use of “parent/caregiver” guidance.**



The DHA authorized an exception to policy for telehealth capabilities covering applied behavioral analysis services. TRICARE **permitted unlimited use of “parent/caregiver” guidance** through telehealth services if authorized by the contractor.

Source: DoD OIG analysis of DHA policy and data requests, 2022.

## TELEHEALTH USE IN TRICARE DURING THE COVID-19 PANDEMIC

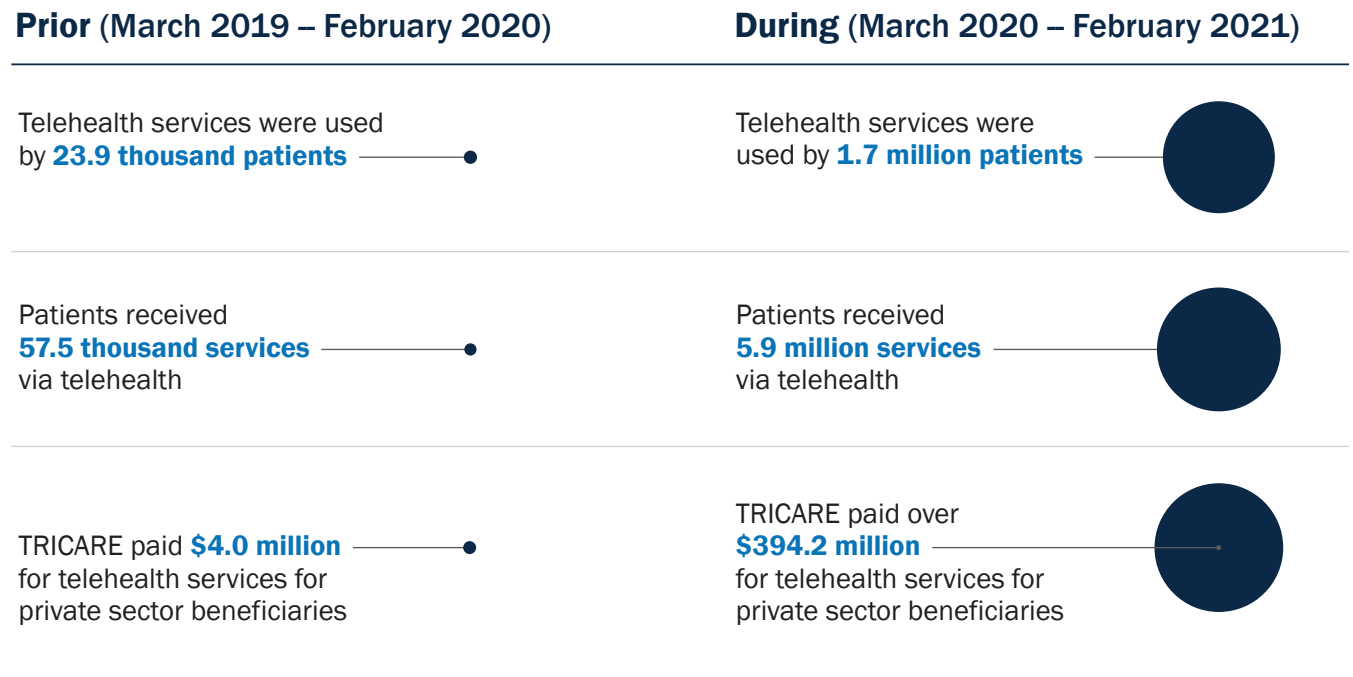
**During the first year of the COVID-19 pandemic, approximately 1.7 million TRICARE private sector beneficiaries used telehealth services.**

During the first year of the COVID-19 pandemic, from March 2020-February 2021, approximately 1.7 million TRICARE private sector beneficiaries used telehealth services. These beneficiaries represent 49 percent of the 3.5 million TRICARE private sector participants.

**Beneficiaries used 102 times as many telehealth services during the first year of the COVID-19 pandemic than they did the prior year.**

TRICARE private sector beneficiaries used approximately 5.9 million telehealth services during the first year of the COVID-19 pandemic—102 times more than during the prior year. In total, TRICARE paid over \$394.2 million for telehealth services for private sector beneficiaries, compared with only \$4 million paid the prior year. (See Exhibit 2.)

### Exhibit 2: Key Differences in Beneficiary Use of TRICARE Private Sector Telehealth Services Prior to and During the COVID-19 Pandemic



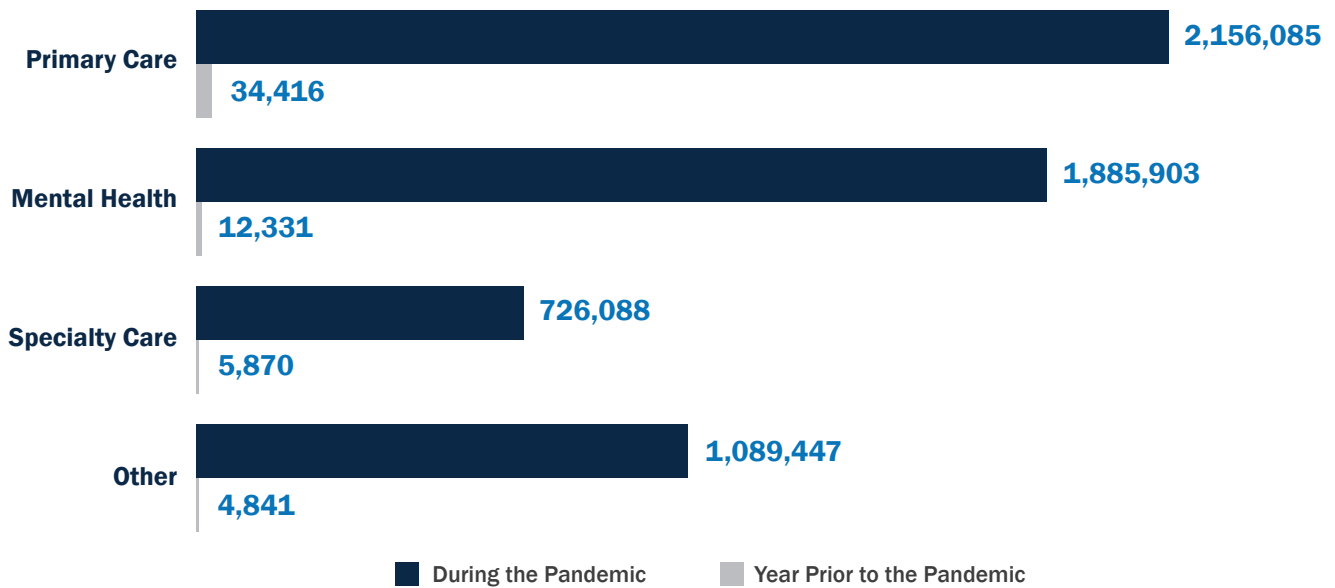
Source: DoD OIG analysis of DHA reported data, 2022.



**Private Sector TRICARE beneficiaries most commonly used telehealth for primary care, mental health, and specialty care.**

According to data provided by the DHA, primary care, mental health, and medical specialty care service types accounted for 81 percent of all telehealth services during the first year of the COVID-19 pandemic. Primary care alone accounted for almost half (40 percent) of all telehealth services during the first year. The “other” category consisted of service types not related to primary care, mental health, or medical specialty care, and accounted for only 19 percent of the telehealth services used during the COVID-19 pandemic. (See Exhibit 3 for a comparison of telehealth claims before and during the pandemic.)

**Exhibit 3: Most common telehealth services during the first year of the pandemic and the year prior**



Source: DoD OIG presentation of DHA reported data, 2022.

## PROGRAM INTEGRITY RISKS RELATED TO TELEHEALTH SERVICES IN TRICARE

The use of telehealth increased substantially during the COVID-19 pandemic and brought changes to TRICARE's telehealth policy. Those changes emphasize the importance of determining whether providers are billing for telehealth services appropriately, identifying ways to safeguard the program, and ensuring quality of care. This section highlights program integrity risks related to billing, quality of care, and data, as well as needed safeguards for telehealth services. We focus on several schemes that providers may be using to inappropriately bill for telehealth services. We also shed light on potential methods for safeguarding the program and ensuring the quality of care for beneficiary telehealth services.

### Program Integrity Risks Related to Billing

#### Data provide insight into potential fraud schemes.

The DHA developed 12 program integrity measures to identify providers whose billing poses a high risk to the TRICARE Program. Specifically, the DHA Program Integrity Division developed the measures based on DHA policy, analysis, and input from TRICARE managed care support contractors. The 12 measures focus on schemes indicating possible fraud, waste, or abuse. (See Exhibit 4 for a list of these measures.)

The managed care support contractors used the measures to identify providers whose telehealth billing poses a high risk to TRICARE. From March 2019 through February 2021, the managed care support contractors identified only a few providers whose telehealth billing poses a high risk to the TRICARE Program. To address the high-risk providers, the managed care support contractors provided education, recouped funds, placed providers on prepayment, and closely monitored a provider.

#### Exhibit 4: Program Integrity Measures

To identify telehealth providers whose billing for telehealth services poses a high risk to TRICARE, the DHA developed 12 measures based on DHA policy, analysis, and input from TRICARE managed care support contractors:

- Billing **duplicate claims**
- Billing **separate components of a procedure instead of billing one single code**
- Billing for **questionable practices**
- Billing **charges more than the allowable rate**
- Billing **issues disclosed through provider voluntary self-reporting**
- Billing for any item or service **furnished during the period during which a provider is excluded from delivering services**
- Billing for services **inappropriate for telehealth delivery**
- Billing telehealth services at the **most expensive level** every time
- Billing **eight plus hours** of telehealth services per day
- Billing applied behavior analysis telehealth services for **hours exceeding an 8-hour day**
- Billing of **outliers for telehealth modifiers and codes**
- Billing both an **originating site fee** and a **distant site fee** for telehealth

Source: DoD OIG presentation of DHA reported data, 2022.

## **An audit revealed that the DHA improperly paid telehealth claims.**

According to a recent DoD OIG audit report, the DHA improperly paid telehealth claims for FY 2020 telehealth services.<sup>59</sup> The DoD OIG reviewed the medical records of 138 beneficiaries and determined that the DHA improperly paid 107 originating site fee claims.<sup>60</sup> The DoD OIG statistically projected that 69 percent of the FY 2020 originating site fee payments completed by the DHA were unsupported by adequate documentation in accordance with DHA and TRICARE policy. Specifically, the DHA improperly paid 67 claims to providers that submitted claims for both originating site fees and distant site telehealth services.<sup>61</sup> In addition, the DHA incorrectly paid 66 originating site claims where the beneficiary received care outside of medical facilities (for example, at home or in a car). These improper payments occurred because the DHA did not implement controls to prevent payment in two different scenarios. First, controls were not adequate to prevent payment when the same provider billed for the originating site and distant site services. Second, controls were not adequate to prevent payment of claims when the beneficiary was not present at the originating site. The DoD OIG also reported that the DHA improperly paid 15 distant site claims that the provider did not code as telehealth visits in accordance with TRICARE policy. Specifically, the DHA did not implement controls to reject improperly coded claims. Because of improperly paid telehealth claims, the DoD OIG projected that the DHA potentially overpaid health care providers for originating site fees by \$620,162 from October 2019 through June 2020.

## **Quality of Care**

### **Potential quality issues increased during the first year of the pandemic for TRICARE.**

According to the TRICARE Operations Manual, the managed care support contractors are required to monitor providers using parameters that address quality of care.<sup>62</sup> Additionally, contractors are required to conduct and report quarterly reviews of medical records to determine the quality of care provided. To emphasize the importance of quality of care and verification of services provided, the TRICARE Policy Manual established minimum documentation requirements, along with specific timeframes for incorporating the information into a beneficiary's medical records.<sup>63</sup> For example, medical records should include the admission evaluation report within 24 hours of admission; a complete history and physical examination report within 72 hours; nursing notes at the end of each shift; and daily physical notes.

According to DHA Program Integrity Division officials, the TRICARE East contractor identified seven potential quality issues related to telehealth before the pandemic (March 2019 to February 2020). However, that number increased to 89 potential quality issues during the first year of the pandemic (March 2020 to February 2021) as providers began the transition to telehealth during the COVID-19 pandemic. TRICARE West contractor officials explained that cases related to the quality of care are not limited to or tracked specifically by telehealth related services. However, the officials stated that they are unaware of any quality issues specifically concerning telehealth services.

## Additional Data Needed for Oversight

### **Telehealth-specific data are needed to better understand the use of telehealth and how it may affect the TRICARE Program.**

The DHA lacks the necessary data to distinguish between clinical and telehealth services. Due to the substantial increase in the use of telehealth during the COVID-19 pandemic, improving TRICARE data specific to telehealth is critical to monitoring the DoD TRICARE Program and identifying providers that pose a high risk to the TRICARE Program. Data specific to telehealth can be used to better understand the use of telehealth and how it may affect the DoD TRICARE Program.

The recent 2020 DHA Program Integrity Division Operational Report identified improvements required to oversee health care anti-fraud activities to protect benefit dollars and safeguard beneficiaries.<sup>64</sup> According to the 2020 DHA Program Integrity Division Operational Report, TRICARE’s managed care support contractors reported that calendar year 2020 prepayment duplicate denials totaled over \$450,000. However, DHA Program Integrity Division officials stated that they cannot determine whether these pre-payment duplicate denials relate to telehealth services. According to DHA Program Integrity Division officials, the Government only requires the managed care support contractors to report an aggregate number of prepayment duplicate denials and not breakdown their data to the specific place of service.

Additionally, the 2020 DHA Program Integrity Division Operational Report states that the DHA requires contractors to have a pharmacy daily claims audit process. However, the DHA Program Integrity Division officials stated that they could not determine whether the daily claims audit process was relevant to telehealth. Furthermore, the DHA Program Integrity Division officials stated that the daily claims audit does not indicate whether providers performed medical services via telehealth or in the office.

## Current Program Integrity Safeguards Used by the DHA

To address program integrity risks related to telehealth, the DHA uses tools such as pre-payment edits; post-payment utilization reviews; fraud hotlines; and pre- and post-payment duplicate screening.<sup>65</sup> The DHA also encourages providers to conduct voluntary self-evaluations and make voluntary disclosures. When appropriate, the DHA can also take actions such as to exclude or suspend providers from the TRICARE Program. The DHA surveys contractors to determine what safeguards the contractors have in place to ensure the integrity of the TRICARE telehealth program. For example, one TRICARE managed care support contractor built some internal oversight mechanisms, such as data analytics dashboards, to identify providers that billed more than 8 hours of telehealth services in one day and applied behavioral analysis provider hours during the COVID-19 pandemic. Another TRICARE managed care support contractor established a review method to prevent inappropriate telehealth reimbursement; created automated system edits to review or reject claims that do not meet specific criteria; and used fraud detection software to detect abnormal telehealth usage.

## NEEDED PROGRAM INTEGRITY SAFEGUARDS

To improve program integrity for TRICARE telehealth services, the DoD OIG in a recent report recommended that the DHA take the following specific actions:

- » **establish controls that prevent payments of originating site fee claims when the originating site and distant site provider are the same;**
- » **establish controls that prevent payment of improperly coded telehealth claims;**
- » **establish controls that require both patient and provider location for telehealth claims;**
- » **review FY 2020 telehealth claim payments to recover improperly paid claims; and**
- » **establish controls that prevent payment of services inappropriate to telehealth delivery.**<sup>66</sup>

# Office of Personnel Management

## Federal Employees Health Benefits Program



OPM contracts with over 80 health insurance carriers to provide health care benefits to more than 8 million federal employees, eligible family members, and other eligible individuals through the Federal Employees Health Benefits Program (FEHBP). Contracted FEHBP carriers process and pay health care claims; provide customer service and access to health care providers and hospitals; and deliver other health care related services and benefits, including telehealth services.

**Scope of OPM Review:** This review describes how telehealth services are administered by 10 selected FEHBP carriers. These selected carriers cover a range of carrier sizes and types, providing services as either an experience-rated fee-for-service carrier,<sup>67</sup> an experience-rated health maintenance organization carrier,<sup>68</sup> or a community-rated health maintenance organization carrier.<sup>69</sup> The review also provides data on telehealth services used by members enrolled in one of our larger FEHBP plans, covering approximately 68 percent of our total enrolled members, between March 2019 and February 2021. An additional timeframe of March 2021 through December 2021 was reviewed as well, to gain insight into telehealth utilization as the pandemic continued. See Appendix C for OPM OIG’s methodology.

### TELEHEALTH IN THE FEHBP DURING THE COVID-19 PANDEMIC

In response to the COVID-19 pandemic, OPM issued several Carrier Letters<sup>70</sup> in 2020 and 2021, urging carriers to review their preparedness and take necessary steps to provide services for FEHBP members without interruption. Additionally, carriers were encouraged to consider solutions that waive cost-sharing, including for health savings accounts<sup>71</sup> and qualified high deductible health plan<sup>72</sup> options, for testing and telehealth visits to minimize barriers to testing and treatment for FEHBP members. OPM strongly encouraged carriers to: focus on mental health, opioid use disorder, and substance use disorder benefits; leverage telehealth expansion for rural populations and to address provider shortages; and educate members regarding the availability of these services.

**Services:** OPM does not specify the types of services that may or may not be offered via telehealth, but rather leaves this up to the carriers to decide. Therefore, OPM itself did not expand covered telehealth services in response to the pandemic. However, at OPM’s encouragement and direction through Carrier Letter 2020-08 and the Call Letter in 2021, most FEHBP carriers reported that they did expand the services available via telehealth and will continue with the expanded telehealth services post-pandemic.

See Exhibit 1 for more information about the telehealth services carriers reported were covered during the pandemic.

**Members and Providers:** OPM does not specify the types of members or the types of providers who may use telehealth, but rather allows carriers to set their own policies. During the pandemic, members could access telehealth services on-demand by telephone or online video or messaging. This allowed members to receive telehealth services from any setting, through access portals<sup>73</sup> operated by telehealth companies such as Teledoc, AmWell, Doctor on Demand, MeMD, MDLive, or any other local provider's portal. Telehealth services could be accessed via a member's personal smart phone, tablet, or computer, or through devices offered in inpatient treatment used to communicate with providers in a remote setting.

**Payment Rates:** OPM does not set payment rates for services or plan allowances, but does negotiate with carriers to set cost-sharing (including copayments, coinsurance, or deductibles). OPM also regularly issues updated guidance to carriers in the form of carrier letters, encouraging the coverage of various types of care. In 2020 and 2021, OPM did encourage carriers to waive cost-sharing for COVID-19 testing and telehealth visits related to the treatment of COVID-19, to increase access to treatment and continuity of care<sup>74</sup> during the pandemic. See Exhibit 2 for more details on these carrier letters.

**Exhibit 1: Examples of telehealth services that FEHBP carriers reported were covered during the pandemic:**

**Office visits** (such as a visit with a Primary Care Physician or specialist)

**Preventive** (such as an annual wellness visit, diabetes management, or nutritional services)

**Behavioral health** (such as individual or group therapy or psychological testing)

**Substance use disorder** (such as individual or group counseling)

**Physical, Occupational, and Speech Therapy** (such as a physical therapy assessment)

**Cardiac Rehabilitation** (such as a visit with a physician or qualified health care professional, with or without ECG monitoring)

**Cognitive performance** (such as performance testing or therapeutic interventions)

Source: OPM OIG analysis of Claims Data Warehouse data, 2022.



## Exhibit 2: OPM Carrier Letters Mentioning Telehealth Prior to and During the COVID-19 Pandemic

### Prior

**2016-03:** Issued February 2016, OPM encouraged carriers to offer virtual visits. For more information, carriers were directed to accreditation standards issued by the American Telemedicine Association and Utilization Review Accreditation Commission.

**2017-01:** Issued January 2017, OPM encouraged carriers to leverage telehealth and to describe the areas in which telehealth would be implemented or expanded in 2018. The letter especially highlighted cost savings and telehealth behavioral health services.

**2019-01:** Issued January 2019, OPM encouraged carriers to consider leveraging telehealth services to address provider shortages and substance use disorder. Also encouraged carriers to educate members regarding the availability of these services.

**2019-05:** Issued April 2019, OPM strongly encouraged carriers who offered a telehealth benefit to provide OPM information regarding how telehealth was being used in mental health coverage and substance use disorder services.

**2020-01:** Issued January 2020, OPM reiterated assessing telehealth services for substance use disorder treatments.

### During

**2020-02:** Issued March 2020, OPM stated that encouraging members to use telehealth services would help limit the spread of COVID-19. Encouraged carriers to consider waiving cost sharing for testing and telehealth visits related to COVID-19.

**2020-08:** Issued April 2020, OPM stated that carriers who had not already done so should strongly consider waiving cost-sharing for telehealth services associated with the treatment of COVID-19. Clarified coverage for specific plan types related to the safe harbor section of the CARES Act.

**2021-03:** Issued February 2021, OPM stated that it and the carriers have worked and will continue to work together to ensure all FEHBP enrollees have equitable access to diagnostic tests, therapeutics, vaccines, and telehealth coverage. Carriers should leverage ongoing telehealth expansion and member education regarding the availability of telehealth services to address mental health provider shortages.

**2021-05:** Issued April 2021, FEHBP carriers were asked to describe their efforts at ensuring members have equitable access to telehealth coverage related to COVID-19. OPM reiterated the message from carrier letter 2021-03 (see above). OPM encouraged carriers to expand telehealth to address rural populations that lack adequate providers for substance use disorder treatment services. Also, OPM encouraged the delivery of coordinated care leveraging telehealth technologies.

Source: OPM Website, Healthcare and Insurance, <https://www.opm.gov/healthcare-insurance/healthcare/carriers/#url=Carrier-Letters>

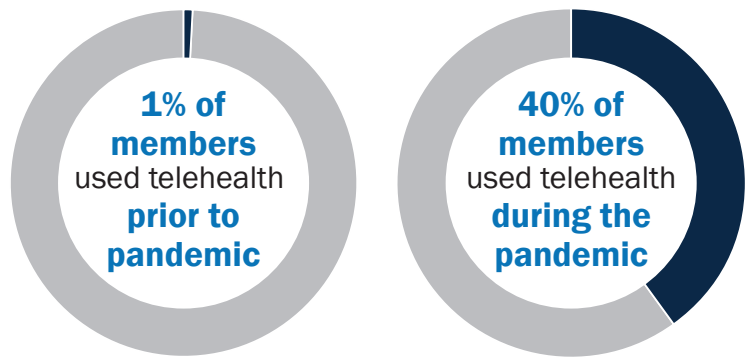
Carriers reported a variety of responses to the suggestion to waive cost-sharing for testing and telehealth visits related to the treatment of COVID-19; most waived members' copayments and coinsurance for at least a portion of 2020/2021 for either all telehealth services or for only those services that led to a COVID-19 diagnosis. However, many of the 10 carriers selected for this review indicated that they have already restored or plan to restore member cost-sharing responsibilities

for telehealth services moving forward. We did note that the member cost-sharing responsibility was most frequently waived when a carrier-contracted telehealth company’s portal was used. Contrastingly, members usually paid a higher copayment when utilizing their local providers’ telehealth portals.

**During the first year of the pandemic, the number of unique FEHBP members who used telehealth services increased by 2,733 percent compared to the prior year.**

From March 2020 through February 2021, a total of 2.2 million unique FEHBP members from one of our larger FEHBP carriers used a telehealth service. These 2.2 million members represented 40 percent of the 5.6 million members enrolled under this carrier, or about 4 in 10 members. This is a dramatic increase from the prior year, when just 1 percent—78,900 in total—of this same FEHBP carrier’s members used telehealth services.

**Exhibit 3: Ratio of Members using Telehealth Prior to and During the COVID-19 Pandemic**

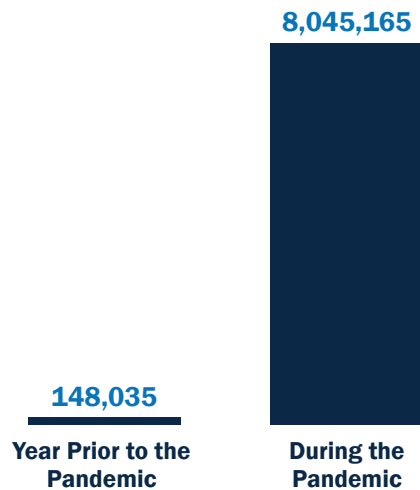


Source: OPM OIG analysis of Claims Data Warehouse data, 2022.

**Telehealth claims increased by 5,335 percent during the pandemic compared to the prior year.**

In total, this same FEHBP carrier’s members filed over 8 million claims for telehealth services during the pandemic period of March 2020 through February 2021. This amounts to over 54 times more telehealth service claims than the 148,035 filed in the prior year. This FEHBP carrier also paid over \$646 million for telehealth services during this same period, which is a 6,259 percent increase—over 63 times more—from the year prior, when only \$10,164,062 was paid for telehealth claims.

**Exhibit 4: Number of Telehealth Claims Prior to and During the COVID-19 Pandemic**

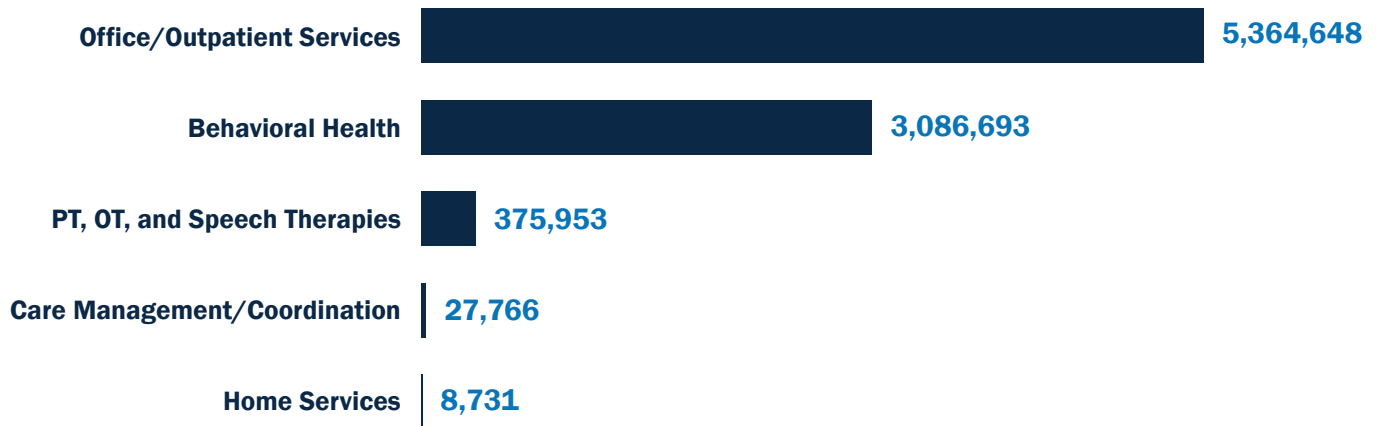


Source: OPM OIG analysis of Claims Data Warehouse data, 2022.  
Note: Data analysis was based on claims data from one carrier, covering approximately 68 percent of enrolled members.

## FEHBP members most commonly used telehealth for office visits and behavioral health services.

For the FEHBP carrier we analyzed, these two service types together accounted for over 91 percent of all telehealth services during the first year of the pandemic. Office visits—routine appointments with primary care providers or specialists—accounted for 58 percent of all telehealth services. In addition, behavioral health services accounted for 33 percent of all services. Behavioral health services include individual therapy, group therapy, and substance use disorder treatment, among others. This carrier’s members also utilized telehealth for physical, occupational, and speech therapies as the third most utilized health care service, although this accounted for just four percent of overall telehealth services. The data from this carrier shows that the trend of members using telehealth for all of these services continued through the end of 2021.

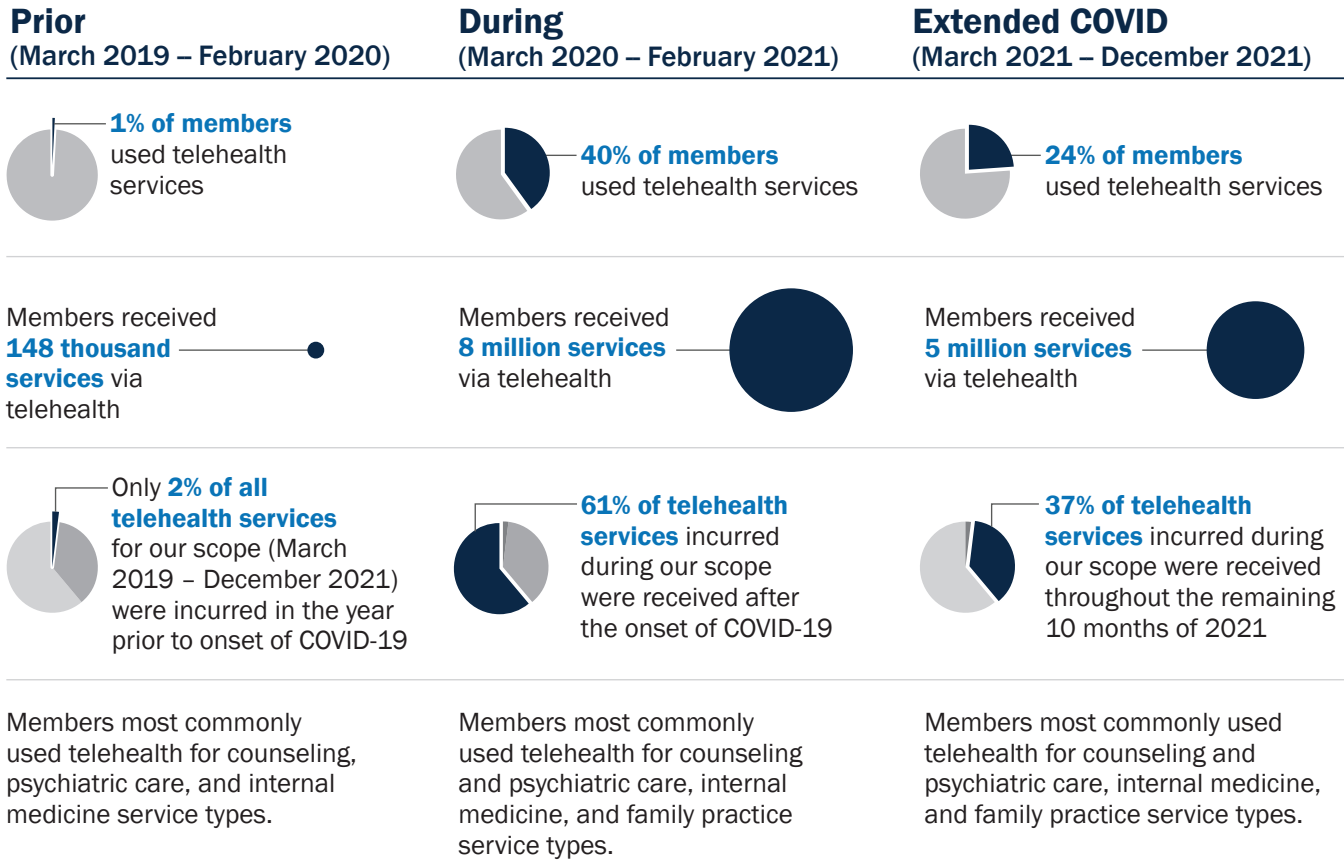
### Exhibit 5: Total Claims for Key FEHBP Telehealth Service Categories During the COVID-19 Pandemic



Source: OPM OIG analysis of Claims Data Warehouse data, 2022.

Note: Data analysis was based on claims data from one carrier, covering approximately 68 percent of enrolled members.

**Exhibit 6: Key Differences in Member Use of FEHBP Telehealth Services Prior to and During the COVID-19 Pandemic**



Source: OPM OIG analysis of Claims Data Warehouse data, 2022.

### **Exhibit 7: Most telehealth services were obtained via a member’s local provider portal, as opposed to a carrier-contracted portal**

For the 10 surveyed carriers, FEHBP members can access telehealth services either via their health insurance carrier’s contracted telehealth company’s portal or via their local preferred provider’s portal. However, claims data for the carrier we analyzed showed that most members received telehealth services from the local preferred provider.

In fact, during our analysis of the claims data, we found that only three percent of telehealth claims incurred during the scope of this review came from the carrier’s contracted telehealth company’s portal. We found this particularly interesting because cost-sharing for members is typically waived when the carrier’s contracted telehealth company’s portal is used, but is not waived when a member chooses to use their local provider’s portal.\* There are several factors that may have contributed to the high ratio of members utilizing their preferred provider’s portals. First, this could suggest that members are willing to pay a small premium in order to obtain services from physicians with whom they may have an established relationship. On the other hand, it could be that not all members were aware of the free telehealth portals available to them. It is also possible that limitations on services available via a carrier’s contracted telehealth company’s portal could have required members to see their local providers for some services. Further work would be needed to determine what influenced members’ decisions as to which type of telehealth visit to utilize.

*\*Note: This distinction does not apply to services related to testing and/or treatment of COVID-19, which requires no copayment, regardless of telehealth portal.*

Source: OPM OIG analysis of Claims Data Warehouse data, 2022.

Note: Data analysis was based on claims data from one carrier, covering approximately 68 percent of enrolled members.

## **PROGRAM INTEGRITY RISKS RELATED TO TELEHEALTH SERVICES IN THE FEHBP**

The dramatic increase in the use of telehealth services since the beginning of the COVID-19 pandemic and the lack of centralized policies for telehealth in the FEHBP underscores the importance of determining whether providers are billing for telehealth services appropriately and of identifying ways to safeguard the program and ensure quality of care.

This section highlights program integrity risks related to billing and quality of care, as well as needed safeguards for telehealth services.<sup>75</sup> We focus on several schemes that providers may be using to inappropriately bill for telehealth services and shed light on potential methods for safeguarding the FEHBP and protecting members’ safety specific to telehealth.

## Program Integrity Risks Related to Billing

### Data analyses provide insight into billing schemes and identify providers whose billing poses a high risk to the FEHBP.

The OPM OIG’s analyses of FEHBP telehealth services claims data shed light on a number of schemes that providers may use to inappropriately maximize their FEHBP payments for telehealth services. We developed six measures that focus on different schemes to identify providers whose billing may indicate fraud, waste, and abuse.<sup>76</sup> See Exhibit 8 for a list of these measures.

Using these measures, we identified over 560 providers whose telehealth billing poses a high risk to the FEHBP. While these providers represent a small proportion of the approximately 265,000<sup>77</sup> providers who billed for a telehealth service between March 2019 and December 2021, their billing raises concern. For example, some providers billed office visit telehealth services at the highest, most complex level every time. In these cases, providers may be delivering higher levels of services than medically necessary or billing for levels of services that were not rendered—a scheme that is sometimes called “upcoding.” In other cases, providers billed for telehealth services for a high number of days in a year. Billing in this manner may indicate that the provider is billing for services that were not provided.

#### Exhibit 8: Program Integrity Measures

To identify telehealth providers whose billing for telehealth services poses a high risk to the FEHBP, OPM OIG developed six measures to analyze:

- Billing telehealth services at the **highest, most expensive level** every time
- Billing telehealth services for a **high number of days** in a year
- Billing a **high average number of hours** of telehealth services per visit
- Billing telehealth services for a **high number of members**
- Billing for telehealth services **unrelated to the providers’ specialty**
- Preferred providers billing high percentages of patients **at long distances**

Source: OPM OIG analysis of Claims Data Warehouse data, 2022.

## Quality of Care and Patient Safety

### Little is known about the impact of telehealth on quality of care in the FEHBP.

Knowing which services and which populations telehealth works best for is critical to help stakeholders make decisions about the use of telehealth services in the future. OPM has specifically recommended expansion of telehealth services to combat the opioid epidemic, mental health provider shortages, and continuity-of-care issues during the COVID-19 pandemic.<sup>78</sup> However, little is known about the effects of telehealth expansion in these areas on quality of care received, patient safety, or FEHBP member outcomes. OPM’s Healthcare and Insurance (HI) does conduct a Plan Performance Assessment annually, which examines quality of care through clinical quality

measures. However, this assessment does not include any telehealth-specific measures. Given the drastic increase in the usage of telehealth services since the onset of COVID-19, we believe that OPM should evaluate whether the annual Plan Performance Assessment currently includes measures that would adequately identify quality of care concerns specific to the telehealth modality.

In addition to oversight by OPM itself, FEHBP carriers should also evaluate telehealth quality of care concerns. In response to our telehealth survey, one carrier indicated that it has a quality plan, which includes performing random audits, diagnosis trending, and utilization monitoring for claims coming in through its contracted telehealth company's portal. However, as discussed above, 97 percent of telehealth services for this carrier were not obtained through this portal. Further, most carriers we surveyed indicated only that quality of care concerns will be reviewed when identified via member grievances. The OPM OIG is not aware of any large-scale reviews specifically examining telehealth's effects on quality of care performed by carriers, though this question was not explicitly posed in our survey.

## Current Program Integrity Landscape in the FEHBP

Currently, each participating FEHBP carrier is responsible for administering its own telehealth benefits, including implementing appropriate integrity safeguards.<sup>79</sup> OPM does not place program-wide restrictions on the types of services eligible to be performed via telehealth, nor does it prescribe any required system edits, audits, or reviews to be performed on telehealth claims.

Further, OPM does not set policy on telehealth service coverage or billing practices within the FEHBP. For example, the responses to our telehealth survey indicated that many carriers waive cost-sharing for services obtained via the telehealth company with which they have a contract, but not for telehealth services obtained via local provider portals. Also, while carriers do typically have edits in place for duplicate payment identification, medical necessity reviews, upcoding, and coordination of benefits,<sup>80</sup> the results of our telehealth carrier survey revealed that some carriers have waived some or all of these edits for telehealth claims. Further, most carriers we surveyed do not have edits in place to check for impossible days<sup>81</sup> for telehealth providers. Most carriers who responded to our telehealth survey did indicate that they perform provider education on telehealth billing. In addition, the OPM OIG does maintain a health care fraud hotline that FEHBP members can contact if they have concerns about care they received or a suspicious billing practice.

In general, we found that most FEHBP carriers we surveyed have somewhat comprehensive policies and procedures in place for oversight of carrier-contracted telehealth company's portals. However, as mentioned above, services obtained through these portals account for a very small percentage of FEHBP telehealth claims. A much greater portion of telehealth services are acquired through a member's local, preferred provider.<sup>82</sup> Our review found that oversight of telehealth in these situations was extremely limited. Providers may use essentially any technology they desire to perform their telehealth services, frequently with little, if any, education, or oversight. In response to our survey questions, many carriers indicated that the providers must follow applicable laws



and regulations. However, the carriers did not list which regulations applied nor did they indicate that any oversight was performed to determine whether providers are actually abiding by relevant requirements.

Finally, OPM has so far left all guidance on telehealth up to the carriers to issue. However, several of the carriers we surveyed indicated that they do not educate providers on telehealth privacy concerns and most carriers indicated they have no requirements regarding recording of telehealth sessions, even to obtain the members' consent before doing so. Currently, it seems the onus is largely on FEHBP members themselves to identify suspicious billing practices, privacy and security concerns, or quality of care issues and report these to their carrier or to the OPM OIG fraud, waste, and abuse hotline.<sup>83</sup> OPM has thus far maintained a relatively hands-off approach to telehealth benefit application and oversight in the FEHBP. This, in combination with the effects of the unprecedented circumstances of the COVID-19 pandemic, has led to greatly varied approaches to telehealth by various carriers.

## PROGRAM INTEGRITY SUGGESTED SAFEGUARDS

The OPM OIG's analyses have raised concerns regarding FEHBP program integrity as it relates to telehealth. In this section, we will lay out these concerns and suggest actions OPM could take to alleviate them and strengthen oversight of telehealth in the program.

First, while analyzing the current program integrity measures described above, we also noticed a pattern of claims submitted with a telehealth modifier or place of service which seemingly could not physically be performed via telehealth. For example, one provider submitted a claim for procedure code 00830 – anesthesia for hernia repairs in lower abdomen. Another included procedure code 11000 – debridement of extensive eczematous or infected skin. While further analysis is needed on these types of claims, their occurrence raises concerns regarding the lack of restrictions or review placed on telehealth claims in the FEHBP in general. We believe OPM should develop and maintain a list of services for which FEHBP providers may be reimbursed when performed via telehealth and require carriers to place edits in their claims systems which will check telehealth claims against this list. OPM could start with the list maintained by CMS,<sup>84</sup> expanding the allowed services if desired.

### Key Suggested Safeguards Related to Carrier Policies:

- » OPM should develop and maintain a list of services for which FEHBP providers may be reimbursed when performed via telehealth and require carriers to place edits in their claims systems which will check telehealth claims against this list.
- » OPM should consider implementing telehealth portal requirements, to protect the privacy of FEHBP members, as well as to reduce the likelihood of technical problems around the availability of these services when needed.
- » OPM should specify the telehealth laws and regulations with which FEHBP providers must comply and require FEHBP carriers to ensure providers are doing so.
- » OPM should issue guidance to FEHBP members on telehealth privacy and security awareness.

Source: OPM OIG analysis of Claims Data Warehouse data, 2022.

As discussed above, carriers indicated that FEHBP providers must follow applicable laws and regulations but did not indicate that any oversight was performed to determine whether providers are abiding by relevant requirements. Therefore, we believe there are safeguards OPM should implement in this area. First, while OPM has pointed carriers towards telemedicine accreditation standards published by the American Telemedicine Association and URAC,<sup>85</sup> OPM has not issued any actual requirements for telehealth portal acceptability. Due to the wide variety of, and in many cases lack of, security and privacy controls around preferred provider telehealth portals, we urge OPM to consider implementing telehealth portal requirements, to protect the privacy of FEHBP members, as well as to reduce the likelihood of technical problems around the availability of these services when needed. In addition, OPM should specify the telehealth laws and regulations with which FEHBP providers must comply and require FEHBP carriers to ensure providers are doing so.

As stated above, it seems the onus is largely on FEHBP members themselves to identify suspicious billing practices, privacy and security concerns, or quality of care issues and report these to their carrier or to the OPM OIG fraud, waste, and abuse hotline. Therefore, we believe OPM should issue guidance to FEHBP members on telehealth-related concerns. For example, OPM could encourage members to review their explanation of benefits documents in detail after each visit to ensure they were billed only for the services they received. Members could also be encouraged to be aware of a provider's surroundings, such as ensuring the provider is in a private location before beginning the session. In addition to issuing guidance to members, we believe OPM HI should review its annual Plan Performance Assessment to determine whether the current measures included adequately address telehealth-specific quality of care concerns.

We believe there is a great need for strengthening effective, targeted oversight of telehealth services in the FEHBP. While OPM has maintained a relatively hands-off approach to telehealth benefit application and oversight, the COVID-19 pandemic has highlighted potentially detrimental gaps in the varied approaches to telehealth by various carriers. We believe centralized guidance that applies to all FEHBP carriers and providers would significantly increase FEHBP member safety and protect the integrity of the FEHBP overall.

# Department of Veterans Affairs

## Veterans Health Administration



The VA runs the largest integrated health care network in the United States. According to VA, as of March 2020 over 9 million veterans were enrolled in VA health care with over 5.6 million active users.<sup>86</sup> VA's medical benefits package provides comprehensive health services, including telehealth, to veterans who are enrolled in VA's health care program.<sup>87</sup>

VA piloted telehealth care as early as the 1960s. In subsequent decades, VA telehealth grew from efforts localized at VA facilities to a national program.<sup>88</sup> In the early 2000s, VA formally established telehealth services within the Office of Patient Care Services to improve quality, convenience, and access to care using telehealth technology.<sup>89</sup> VA also developed clinical video telehealth, which allowed VA providers to diagnose and often treat veterans in real time via interactive, live video. In 2016, VA established the Office of Connected Care to administer telehealth programs throughout VA. In 2017, VA launched its VA Video Connect (VVC) mobile app to provide a secure environment for patients and providers to carry out video telehealth visits, regardless of where the veteran and provider were located. Clinical video telehealth and VVC allow providers to use videoconferencing to assess, treat, and provide care to veterans remotely. VA clinicians also provide telehealth care via telephone.

In 2018, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act authorized providers employed by VA to deliver telehealth across state lines, regardless of where the patient or provider were located or in which state the provider was licensed.<sup>90</sup> The MISSION Act also established the Veterans Community Care Program. Through this program, VA pays for care, including telehealth, provided by community providers in networks managed by third-party administrators (TPAs) under certain conditions, including when care cannot be delivered to veterans by VA providers at VA medical facilities. TPAs pay non-VA providers within the network they manage for claims and then submit invoices directly to VA for reimbursement. VA's cost for community care was about \$16.9 billion in fiscal year 2020.<sup>91</sup> According to VA, about 2.1 million unique veterans used community care in fiscal year 2020.

**Scope of VA OIG Review:** This review describes outpatient synchronous telehealth services between VA providers and enrolled veterans, and between enrolled veterans and non-VA providers in the community.<sup>92</sup> For our analysis of telehealth services provided by VA providers, we included video and telephone encounters. The types of services included primary care, behavioral health care, medical and surgical specialty care, and ancillary services.<sup>93</sup> The time frames of our review

of telehealth services provided by VA providers are the year before the COVID-19 pandemic, March 2019 through February 2020, and the first year of the COVID-19 pandemic, March 2020 through February 2021.

For our analysis of telehealth services provided by non-VA community providers to veterans, we analyzed data from VA claims processing systems for paid community care telehealth claims from March 1, 2019, through December 31, 2021.<sup>94</sup> We extended the scope of our review of community care telehealth claims beyond the first year of the pandemic to also include March 2021 to December 2021 due to the ongoing nature of the pandemic.

## VA TELEHEALTH CHANGES AND USE DURING THE PANDEMIC

Beginning in March and April of 2020, VA took actions to expand telehealth services provided by VA facilities to ensure that veterans maintained access to health care and to improve veterans' access to technology during the COVID-19 public health emergency. These actions included, but were not limited to, the following:

- **March 17:** A VA memo to network and facility leaders provided guidance to expedite credentialing and privileging of health care providers in anticipation of staffing shortages.
- **March 19:** VA authorized VHA clinicians to use any third-party audio or video communication technology with privacy features for telehealth appointments.
- **March 22:** A VA memo advised that veterans with non-urgent appointments who were concerned about exposure to COVID-19 could access health care via telephone appointments or telehealth or have the option to postpone and reschedule.
- **March 23:** VA's Office of Emergency Management COVID-19 response plan included that VA would provide most outpatient care for veterans through telehealth.
- **April 27:** VHA issued a new directive allowing VA employed health care professionals to provide telehealth services through any VA facility without re-credentialing and re-privileging at each facility. The purpose of the directive was to facilitate sharing of clinical resources and improve flexible utilization of health care professional services.<sup>95</sup>
- **March 11, 2021:** The American Rescue Plan signed into law allowed VA to reimburse veterans or waive copayments or other cost sharing for care provided from April 6, 2020, through September 30, 2021.

## TELEHEALTH USE IN VA DURING THE PANDEMIC

During the first year of the pandemic, almost 4.8 million veterans had a telehealth encounter. This accounted for 87 percent of the veterans who used VA health care that year and almost twice the number of veterans who used telehealth the previous year. (Exhibit 1.)

### Exhibit 1: Patient Health Care Encounters

	<i>March 2019– February 2020</i>	<i>March 2020– February 2021</i>
<b>Patients with any health care encounter</b>	5,742,419	5,510,188
<b>Patients with a telehealth encounter</b>	2,334,601	4,794,928
<b>Percent of patients with a telehealth encounter</b>	41%	87%

Source: VA OIG analysis of data from VHA Corporate Data Warehouse.<sup>96</sup>

Note: Percentages are rounded.

The number of video telehealth encounters increased 181 percent in the first year of the pandemic, and telephone encounters increased by 211 percent. (Exhibit 2.)

### Exhibit 2: Video and Telephone Telehealth Encounters

	<i>March 2019– February 2020</i>	<i>March 2020– February 2021</i>	<i>Change</i>
<b>Video encounters</b>	2,187,311	6,137,947	181%
<b>Telephone encounters</b>	6,731,555	20,958,287	211%

Source: VA OIG analysis of data from VHA Corporate Data Warehouse.

Note: Percentages are rounded.

Primary care and behavioral health saw large increases in the number of telephone and video telehealth encounters. Specialty Care and other ancillary services also saw significant increases. (Exhibit 3.)

**Exhibit 3: Telehealth Encounters by Service Type**

	March 2019– February 2020	March 2020– February 2021	Change
<b>Video</b>			
Primary Care	259,246	1,361,288	425%
Behavioral Health Care	1,338,719	3,199,457	139%
Specialty Care	408,546	940,141	130%
Other Ancillary Services	180,800	637,061	252%
<b>Telephone</b>			
Primary Care	3,737,064	11,928,965	219%
Behavioral Health Care	1,031,250	5,290,174	413%
Specialty Care	1,861,506	3,381,882	82%
Other Ancillary Services	101,735	357,266	251%

Source: VA OIG analysis of data from VHA Corporate Data Warehouse.  
Note: Percentages are rounded.

## COMMUNITY CARE AND TELEHEALTH

VA uses the Plexis Claims Manager (Plexis) and the Community Care Reimbursement System (CCRS) to process claims from community care network TPAs. At the time of the pandemic, the TPAs reported that conducting telehealth must be consistent with Medicare guidelines.

### VA Expanded Community Provider Telehealth During the COVID-19 Pandemic

The Centers for Medicare & Medicaid Services (CMS) implemented flexibilities in response to the pandemic that helped Medicare beneficiaries, including veterans receiving care from community providers, gain access to more telehealth services without having to go to a medical facility.<sup>97</sup> For example, in March 2020, CMS waived requirements for providers who were previously ineligible for Medicare telehealth services, including physical therapists, occupational therapists, and speech language pathologists. Waiving the requirements allowed non-VA providers to provide care and receive payments for these services.<sup>98</sup>

Through analyses of claims from non-VA community providers for care that was provided to veterans via telehealth, the impact on the volume of telehealth usage is clear. The scope of this review begins one year before the pandemic, the first full year of the pandemic, and then an additional ten months thereafter to the end of December 2021, reflecting the ongoing nature of the pandemic.

### Care Provided to Veterans in the Community via Telehealth: Before and During the COVID-19 Pandemic

In the 12 months before the pandemic (March 2019 through February 2020), less than one percent of veterans who received care in the community did so at least once via telehealth. From March 2020 through February 2021, however, about 19 percent of the 871,000 veterans who received care in the community did so at least sometimes via telehealth. Fewer veterans received at least some telehealth care in the community from March 2021 through December 2021—only 8 percent of about 1.1 million veterans.<sup>99</sup>

#### Exhibit 4: Percentage of Veterans Using Telehealth in the Community



Source: VA OIG analysis of VA community care telehealth claims data as of December 2021.

Note: Percentages are rounded.



Exhibit 5 details what VA paid for all community telehealth services prior to the pandemic and during it. In total, VA spent about \$101.8 million on approximately 830,000 community care telehealth claims for about 215,000 veterans between March 2019 and December 2021.<sup>100</sup>

**Exhibit 5: Growth of Community Telehealth Claims Prior to and During the Pandemic**

	<i>March 2019– February 2020</i>	<i>March 2020– February 2021</i>	<i>March 2021– December 2021</i>
<b>Number of claims paid</b>	27,500	537,000	267,000
<b>Amount paid (millions)</b>	\$3.4	\$62.0	\$36.5

Source: VA OIG analysis of VA community care telehealth claims data as of December 2021.

Note: Numbers are rounded.

VA most frequently paid for community behavioral health services that were provided using telehealth.<sup>101</sup> This category of care accounted for about 59 percent of the claims submitted from March 2019 through December 2021 and represented about \$65.2 million in costs. In this category, the most commonly paid service was psychiatry care. This care also accounted for the most claims paid during each of the time periods we reviewed.

The next most common type of community telehealth claim from March 2019 through December 2021—office visits—represented about 243,000 claims. VA paid about \$21 million for the category of “evaluation and management, office visit-established care” during this time period. Slightly over half of unique veterans (118,000 of about 215,000) who received care in the community via telehealth received these kinds of visits. This care also accounted for the second-most claims paid during each of the time periods we reviewed.

Veterans’ use of telehealth during our period of review increased, regardless of whether care was provided in VA or by community providers. Veterans received care from both VA and community providers and continued to do so via telehealth when the COVID-19 pandemic limited in-person care. In fact, VA had been making investments into its in-house telehealth program prior to the pandemic.

## PROGRAM INTEGRITY RISKS ASSOCIATED WITH TELEHEALTH IN VA

The dramatic changes that came from expanding veteran community care via telehealth during the pandemic exposed VA to several program integrity risks, including whether VA was being charged the right amount for care provided to veterans by non-VA providers in the community via telehealth. We also identified risks for VA's program that lends veterans devices for video care.

### Quality of Care and Patient Safety

Oversight of quality and patient safety processes are necessary to ensure that patients receive safe and effective health care. For care furnished by VA providers, mandatory credentialing and monitoring of care ensures that health care providers in occupations that require maintaining state licensure, certification, and monitoring of time limited credentials are consistently evaluated on employment and every two years as required.<sup>102</sup> This requirement does not apply to health care providers furnishing health care, including telehealth care, in the community. The MISSION Act requires non-VA community providers meet certain eligibility requirements, such as having an unrestricted state license to practice, eligibility to participate in federally funded health care programs like Medicare and Medicaid, and other credentialing standards. Providers who were suspended or removed from VA employment for quality of care concerns must be excluded from the community care network. The credentialing of community providers is conducted by VA's contractors and is outside the scope of this review.

Ongoing studies are necessary to further evaluate the effect of telehealth on quality of care during the COVID-19 pandemic. These studies could evaluate appropriateness of care, readmission rates, delay in diagnoses, patient satisfaction, barriers to care, and standardized quality metrics and guidelines.

### Program Integrity Risks Related to Community Care Telehealth Claims

Increased community care telehealth claims put VA at risk of fraud and of making inaccurate payments. Fraud schemes can include, for example, a provider billing for telehealth appointments occurring at the same time or with multiple veterans located in multiple locations that providers could not possibly reach during the time frame.<sup>103</sup> From March 2019 through December 2021, we identified about \$22.3 million of \$101.8 million unique community care telehealth claim payments (about 22 percent) in four areas that may have exposed VA to increased risk, and some of the payments exhibited multiple risks.<sup>104</sup> We did not review detailed provider information and veterans' health records to determine whether these claims were valid.<sup>105</sup> If VA can identify improper payments or ones made in error, the payments can be addressed. In the sections that follow on the risks that telehealth poses to VA's community care program, our narrative focuses on the first year of the pandemic (March 2020 through February 2021) to allow readers to readily compare VA's risks with those of other federal agencies discussed in this report. However, our data tables include an additional ten months of data (March 2021 through December 2021) to reflect the ongoing nature of the pandemic.

## Ineligible Services

From March 2020 through February 2021, VA spent about \$62 million on community care via telehealth claims, of which about \$2 million (or about 3.2 percent of spending) were for ineligible telehealth services. For example, during this period, claims for the fitting, orientation, and checking—as well as the repair and modification—of hearing aids were not included in the schedule of telehealth services. VHA spent about \$671,000 on these services. Exhibit 6 provides a summary of the community telehealth claims we identified that were paid for ineligible services.

### Exhibit 6: Ineligible Telehealth Services by Veterans, Claims, and Amounts Paid

	<i>March 2019– February 2020</i>	<i>March 2020– February 2021</i>	<i>March 2021– December 2021</i>
<b>Veterans with one or more ineligible claim</b>	290 of 6,100 (4.8%)	3,500 of 164,000 (2.2%)	2,400 of 81,600 (3.0%)
<b>Number of ineligible claims</b>	360 of 27,500 (1.3%)	6,700 of 537,000 (1.2%)	6,500 of 267,000 (2.5%)
<b>Amount paid for ineligible claims</b>	\$88,700 of \$3.4 mil (2.6%)	\$2.0 mil of \$62.0 mil (3.2%)	\$1.8 mil of \$36.5 mil (5.0%)

Source: VA OIG analysis of VA community care telehealth claims data as of December 2021.

Note: Numbers and percentages are rounded.

## High-Usage Days

We consider a high-usage day to be when a community care provider billed for a significant number of hours in a single day. High-usage days could reflect fraudulent billing activities or could reflect legitimate billing. For this analysis, we define a high-usage day as one in which a community provider billed for more than 18 hours of telehealth services. From March 2020 through February 2021, VA paid approximately \$578,000 (or less than 1 percent of spending) for 3,400 claims that were associated with high-usage days, as summarized in Exhibit 7.

**Exhibit 7: Summary of Potentially Invalid Community Telehealth Billing for 18 Hours or More in a Single Day**

	<i>March 2019– February 2020</i>	<i>March 2020– February 2021</i>	<i>March 2021– December 2021</i>
<b>Number of claims</b>	66 of 27,500 (0.2%)	3,400 of 537,000 (0.6%)	1,100 of 267,000 (0.4%)
<b>Number of providers</b>	15 of 1,900 (0.8%)	56 of 60,400 (0.1%)	13 of 29,100 (0.0%)
<b>Amount paid</b>	\$7,100 of \$3.4 mil (0.2%)	\$578,000 of \$62.0 mil (0.9%)	\$191,000 of \$36.5 mil (0.5%)

Source: VA OIG analysis of VA community care telehealth claims data as of December 2021.  
Note: Numbers and percentages are rounded.

**High-Intensity Evaluation and Management Claims**

Evaluation and management services include assessing a patient’s history or examining a patient to make a medical decision. For this analysis, we selected claims for community care telehealth associated with evaluation and management codes. These claims were also reimbursed at higher levels than other evaluation and management claims. In particular, we defined high-intensity evaluation and management as claims that require a moderate to high level of decision making because of their complexity. To identify potential risks, we identified community providers who were billing VA with at least one high-intensity evaluation and management claim during the review period. From March 2020 through February 2021, VA’s health care program paid approximately \$10.7 million (about 17 percent of spending) to about 23,400 community providers for about 100,000 high-intensity evaluation and management claims.<sup>106</sup>

**Exhibit 8: Summary of High-Intensity Evaluation and Management Community Telehealth Claims**

	<i>March 2019– February 2020</i>	<i>March 2020– February 2021</i>	<i>March 2021– December 2021</i>
<b>Number of claims</b>	4,300 of 27,500 (16%)	100,000 of 537,000 (19%)	40,700 of 267,000 (15%)
<b>Number of providers</b>	520 of 1,900 (27%)	23,400 of 60,400 (39%)	10,900 of 29,100 (38%)
<b>Amount paid</b>	\$510,000 of \$3.4 mil (15%)	\$10.7 mil of \$62.0 mil (17%)	\$5.1 mil of \$36.5 mil (14%)

Source: VA OIG analysis of VA community care telehealth claims data as of December 2021.

Note: Numbers and percentages are rounded.

**Duplicate Claims**

We considered a telehealth claim to be a potential duplicate if it was paid for the same veteran, community provider, date of service, and current procedural terminology (CPT) code as at least one other claim. Telehealth duplicate claims were classified by their existence within a single claims processing system, Plexis or CCRS, or within both systems. Community providers also submitted potentially duplicate claims for services provided both as telehealth and in-person.

From March 2020 through February 2021, VA paid approximately \$1.5 million for about 14,000 possible duplicate telehealth claims involving about 1,900 community providers. These claims represented about 2.4 percent of total spending on community care telehealth claims. Exhibit 9 provides additional details on the duplicate claims we identified.

**Exhibit 9: Summary of Potentially Duplicate Claims**

	<i>March 2019– February 2020</i>	<i>March 2020– February 2021</i>	<i>March 2021– December 2021</i>
<b>Number of claims</b>	400 of 27,500 (1.5%)	14,000 of 537,000 (2.6%)	670 of 267,000 (0.2%)
<b>Amount paid</b>	\$35,400 of \$3.4 mil (1.0%)	\$1.5 mil of \$62.0 mil (2.4%)	\$119,000 of \$36.5 mil (0.3%)

Source: VA OIG analysis of VA community care telehealth claims data as of December 2021.

Note: Numbers and percentages are rounded.

## Community Care Telehealth Claims Processing Has Limited Controls

Neither Plexis nor CCRS has a system in place to identify claims associated with ineligible services, potential high-usage days, or high-intensity evaluation and management services for community care telehealth. A senior VA official reported that VA's post-payment review processes are not designed to identify these types of risks. However, the TPAs provide VA quarterly reports that may include information on claims that may be suspicious.<sup>107</sup> A VA official familiar with claims processing compliance reported that TPA personnel should notify VA of any suspicious provider activity, but TPA personnel have not discussed the risks identified in this summary with VA.

Regarding duplicate claims, there are processes in place in Plexis and CCRS to reject or deny such claims. In addition, VA's Program Integrity Tools generate a report that identifies potential duplicates between Plexis and CCRS. VA personnel research these claims and coordinate with the TPAs to determine whether the payments are valid.

## Review Revealed Opportunities to Improve VA's Digital Divide Program

In August 2020, VA's Office of Connected Care recognized the growing demand for patient access to video-based virtual care, and that many patients lack a video-capable device or the internet connection required to access this care.<sup>108</sup> To help these individuals, VA introduced the digital divide consult, where patients are lent a video-capable device after obtaining a referral from their care team, licensed independent practitioner, or designee, and the approval of a social worker who has conducted a socioeconomic assessment.<sup>109</sup> The digital divide consult improved on a 2016 device lending process by introducing the social worker assessment to help identify and resolve other needs and barriers to care.

We found that the VA's digital divide program was successful in distributing devices to patients, but identified several gaps in oversight and guidance preventing the program from fully meeting its intended purpose for patients to receive virtual care via VVC. VA's standard operating procedure (SOP) includes eligibility criteria purposely left broad in light of the pandemic and does not require scheduling the patient for a VVC appointment.<sup>110</sup> After introducing the digital divide consult, VA issued devices (iPads) to about 41,000 patients during the first three quarters of fiscal year 2021. These devices were not always used to connect to video telehealth, as only an estimated 20,300 of those patients (about 49 percent) with issued devices completed a VVC appointment. The remaining patients (about 51 percent) had not used the devices for VVC appointments.

- An estimated 10,700 patients never had a VVC appointment scheduled, as there was no requirement to schedule, and neither the patient nor the staff initiated scheduling a VVC appointment.
- We estimated that more than 10,000 patients had a VVC appointment scheduled but did not complete the VVC visit for various reasons, such as technical issues or a cancellation, and a subsequent VVC appointment was not completed.

We also found lapses in device issuance and management during the review of VA's tablet dashboard data. Specifically, we determined that VA staff did not retrieve about 8,300 unused devices to make them available to other patients when they did not have VVC activity, as required by the SOP. The value of the devices was about \$6.3 million and cost VA about \$78,000 in additional cellular data fees during the period under review. When VA does not retrieve and update its loaned, unused devices, it cannot make them available to other patients.

We also determined that as of January 2022, there was a backlog of about 14,800 returned devices pending refurbishment before they could be redistributed. The returned devices accumulated primarily because of technical issues with the refurbishment system VA used. As a result, these devices were not logged into shippable inventory and were not available to be distributed to other patients. Despite the backlog, VA did not suspend purchases of new devices from its contractor and placed a purchase order for additional new devices in August 2021. As of December 2, 2021, VA bought 9,720 devices under this purchase order, totaling about \$8.1 million.

Regarding the positive value that this program provided veterans, VHA noted an April 2022 study that found veterans with a history of mental health care use and in receipt of a video-enabled tablet were associated with increased use of mental health services via video, increased psychotherapy visits across all modalities, and reduced suicidal behavior and emergency department visits.<sup>111</sup>

VA-loaned devices represent a sizeable investment and should be closely monitored. The importance of remote care has been highlighted by the COVID-19 pandemic and capitalizing on the best use of resources set aside for video-based care will continue to be an important aspect of this program and VA's operations. We made recommendations for continued program development relevant to oversight roles and responsibilities, revising standard operating procedures, enhancing device monitoring and retrieval controls and oversight, implementing more detailed device refurbishment reporting, and using such data when considering new device purchases.

## CONCLUSION

VA operated a robust telehealth program prior to the pandemic. VA made a noticeable effort to expand remote medical services that resulted in more veterans and beneficiaries being able to take advantage of telehealth appointments, particularly during the COVID-19 pandemic. However, upon review, we noted that there was room for improvement in telehealth and related services that would reduce risk, free up funds, and improve the veteran experience.



# Office of Workers' Compensation Programs



DOL's Office of Workers' Compensation Programs (OWCP) administers four major disability compensation programs that provide wage replacement benefits, medical treatment, vocational rehabilitation, and other benefits to eligible workers, or their survivors, who experience work-related injury or occupational disease:

1. the Federal Employees Compensation Act (FECA) program, which provides benefits to federal employees injured on the job;
2. the Black Lung program, which provides benefits to coal miners who suffer from Black Lung disease as a result of coal mine employment;
3. the Energy program, which provides benefits to Department of Energy (DOE) employees and contractors, atomic weapons employees, and uranium workers exposed to toxic substances on the job; and
4. the Longshore program, which provides benefits to injured employees engaged in maritime work or in maritime occupations on the navigable waters of the United States or adjoining areas.<sup>112</sup>

Workers who suffer work-related injury or occupational disease file a claim with the appropriate workers' compensation program. Eligible claims are approved for compensation and/or medical benefits, with OWCP paying 100 percent of the cost for claimants. OWCP determines the appropriateness<sup>113</sup> of and sets payment rates for services required to treat any accepted medical conditions. To bill OWCP for services, medical providers must enroll with OWCP, self-certify that they meet all applicable federal and state licensure and regulatory requirements, and maintain supporting documentation for the self-certification.

**FECA Program:** The FECA program covers approximately 2.6 million civilian federal employees, including U.S. Postal Service employees, in more than 70 different agencies. The FECA program pays for services, appliances, and supplies prescribed by a qualified physician that OWCP deems likely "to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation"<sup>114</sup> for the injured worker.

In Fiscal Year (FY) 2021, the FECA program provided \$2.938 billion in benefits to more than 183,000 workers and survivors for work-related injuries or illnesses. Of these benefits payments,

\$771 million was for medical benefits and rehabilitation services.

**Black Lung Program:** The Black Lung program provides compensation to coal miners who are totally disabled by pneumoconiosis<sup>115</sup> arising out of coal mine employment. The program also provides eligible miners with medical coverage for the treatment of lung diseases related to pneumoconiosis. There are two parts to the program. Part B benefits are paid by the Federal Government to miners and eligible survivors who filed a claim on or before December 31, 1973; Part C benefits are paid by self-insured coal mine operators or insurance carriers for claims filed after 1973. However, when no coal mine operator can be held liable for payments, the Federal Government pays Part C benefits from the Black Lung Disability Trust Fund (Trust Fund), which is primarily funded by an excise tax on coal produced and sold domestically. Part B benefits do not include medical benefits. Miners who receive Part B benefits are required to file for medical benefits under Part C. The Black Lung program does not maintain telehealth data on Part C benefits paid by coal mine operators or insurance carriers; therefore, this report only includes telehealth information on Part C benefits paid out of the Trust Fund.

In FY 2021, the Black Lung program served about 5,900 beneficiaries and paid approximately \$50.6 million under the Part B program; likewise, it paid over \$149 million in benefits to about 15,500 Part C beneficiaries. The Black Lung program also monitored benefits paid by responsible coal mine operators to another approximately 8,900 beneficiaries.

**Energy Program:** Part B of the Energy Employees Occupational Illness Compensation Act provides a fixed amount of compensation and medical coverage to DOE employees and contractors, atomic weapons employees, and uranium workers with specified medical conditions, including cancer. Part E of the act pays variable cash benefits up to a maximum amount based on impairment and wage loss and provides medical benefits to former DOE contractors and uranium workers exposed to toxic substances on the job.

From the beginning of the program in July 2001<sup>116</sup> to March 2022, the Energy program paid over \$13 billion in compensation for almost 134,000 claims and over \$7.7 billion in medical benefits.

**Longshore Program:** The Longshore program offers workers' compensation protection to employees engaged in maritime work or in maritime occupations on the navigable waters of the United States or adjoining areas. The Longshore program generally does not directly pay benefits to injured workers.<sup>117</sup> Rather, it oversees the award and delivery of benefits, which are provided by self-insured private employers or insurance carriers. Because the Longshore program does not maintain data on telehealth services provided by these self-insured employers and insurance carriers, the Longshore program will not be included in this report.

**Scope of DOL Review:** This review describes telehealth services provided by physicians and other medical practitioners. Telehealth services refer to services that are provided remotely using technology between a medical provider and a claimant. This review includes data on telehealth services provided by OWCP's FECA, Black Lung, and Energy programs.

## OWCP TELEHEALTH POLICY CHANGES DURING THE PANDEMIC

As a result of the COVID-19 pandemic, the FECA, Black Lung, and Energy programs instituted new policies that expanded access to telehealth for injured workers by allowing routine medical care to be provided through telehealth by certain types of medical care practitioners. The Energy program further expanded telehealth services, temporarily allowing physicians to evaluate claimants through telehealth to determine a need for home health care or durable medical equipment. Prior to the pandemic, only the FECA program allowed telehealth. See Exhibit 1 below.

**Services:** In 2020, the OWCP programs expanded access to telehealth at varying degrees. While the FECA program had allowed telehealth prior to the pandemic, the Black Lung and Energy programs had not. The FECA program did not have a formal telehealth policy prior to the pandemic, but in October 2020, it instituted a new policy on telehealth services and published a list of 54 medical procedures for which telehealth would be allowed.<sup>118</sup> The services ranged from routine medical appointments that normally take place in a doctor's office to physical therapy and other virtual care services, such as a telephone call with a provider to discuss a claimant's medical condition.

The Black Lung program also started allowing telehealth for routine medical appointments during the pandemic. In June 2020, the Black Lung program instituted a new policy allowing telehealth for office visits, physical examinations, health screening, diagnostic testing, and treatment for an illness or non-emergency medical condition. There are now 10 medical procedures for which telehealth is allowed as routine medical care. The Black Lung program is currently in the process of expanding telehealth beyond routine services. Additional services are currently being paid on an exception basis, provided the bills are submitted with an acceptable place of service,<sup>119</sup> acceptable modifier,<sup>120</sup> and the appropriate attachment for telehealth services.<sup>121</sup>

In April 2020, the Energy program established a new policy to temporarily allow telehealth for physicians to provide routine non-emergency medical care and to evaluate claimants to determine medical necessity for home health care and durable medical equipment. OWCP management indicated the Energy program allowed 44 medical procedures for telehealth since implementation of the policy. While the temporary telehealth policy for home health care and durable medical equipment was extended until September 2022, the telehealth policy for routine non-emergency medical care has been made permanent as of December 2021.

For all three OWCP programs, telehealth services can be provided through a real-time interactive audio and video telecommunication system or through an asynchronous method, where medical care is provided through video or image that is not in real-time. However, certain medical procedures cannot be performed through audio only. For example, the Black Lung program requires video communication for virtual services such as virtual check-ins and E-visits,<sup>122</sup> and the Energy program requires face-to-face evaluation using remote video conference with a nurse, nurse practitioner, or physician assistant present to determine medical necessity for home health care and durable medical equipment.

**Claimants and Providers:** The OWCP programs have no limits on claimants receiving telehealth services; however, each program has limited the types of providers who can use telehealth.

- The FECA program limits the types of medical practitioners who can provide telehealth services to physicians, psychologists, social workers, chiropractors, occupational therapists, physical therapists, and podiatrists;
- The Black Lung program allows physicians and other health care professionals who work under a physician's supervision to provide telehealth services when the medical care is associated directly with an accepted medical condition; and
- The Energy program limits telehealth providers to licensed physicians.

OWCP does not require claimants to receive telehealth services only from providers with whom they had an established relationship. Additionally, OWCP does not have an established network of medical providers who participate in its programs. However, all medical providers, including telehealth service providers, must enroll with OWCP. The providers must have legal and licensing authority to provide telehealth services, self-certify that they satisfy all applicable federal and state licensure and regulatory requirements applicable to their specific provider type, and maintain documentation supporting the self-certification.

**Payment Rates:** In the three OWCP programs (FECA, Black Lung, and Energy), telehealth services were paid the same as in-person services. Claimants are not responsible for any portion of telehealth service costs. As a workers' compensation program, the OWCP programs pay 100 percent of all allowed medical services, including telehealth services.

**Exhibit 1: Key Similarities and Differences in Telehealth Policies Among OWCP Programs During the COVID-19 Pandemic**

	<b>FECA</b>	<b>Black Lung</b>	<b>Energy</b>
	Telehealth services were allowed prior to the pandemic, but there was no formal policy.	Telehealth services were not allowed prior to the pandemic.	Telehealth services were not allowed prior to the pandemic. <sup>123</sup>
	Claimants can receive routine medical care (emergency or non-emergency), including physical and occupational therapy, through telehealth permanently.	Claimants can temporarily receive non-emergency, routine medical services through telehealth until further notice.	Claimants can receive non-emergency, routine medical services through telehealth permanently. Evaluations to determine medical necessity for home health care and durable medical equipment through telehealth was allowed on a temporary basis.
	No limitation on the type of claimants who can receive telehealth services.	No limitation on the type of claimants who can receive telehealth services.	No limitation on the type of claimants who can receive telehealth services.
	Physicians, psychologists, social workers, chiropractors, occupational therapists, physical therapists, and podiatrists can provide telehealth services.	Physicians and other health care professionals who work under a physician's supervision can provide telehealth services.	Only physicians can provide telehealth services.
	Telehealth services can be provided through a real-time interactive audio and video telecommunication system or through an asynchronous telecommunication system.	Telehealth services can be provided through phone, video conferencing, or similar technologies.	For routine physician appointments, telehealth services can be provided through phone, video conferencing, or similar technologies. Evaluations of medical necessity must be conducted through video conferencing with a nurse or physician assistant present with the claimant.
	Providers are paid the same rate as in-person services.	Providers are paid the same rate as in-person services.	Providers are paid the same rate as in-person services.

Source: DOL OIG review of OWCP programs' policies and interviews, 2022.

## TELEHEALTH USE IN OWCP PROGRAMS DURING THE PANDEMIC

**During the first year of the pandemic, almost 16,000 OWCP claimants used telehealth services.**

From March 2020 to February 2021, almost 16,000 OWCP claimants used a telehealth service. These claimants represented 10.9 percent of the more than 145,000 OWCP claimants, or about 1 in 10, who received any medical services during this period. This was a dramatic increase from the prior year, when less than 1 percent of OWCP claimants—approximately 500—used telehealth.

**OWCP claimants used 34 times more telehealth services during the first year of the pandemic than they used in the prior year.**

In total, from March 2020 to February 2021, OWCP claimants used about 58,000 telehealth services. This amounted to 34 times more telehealth services than the prior year when only about 1,700 telehealth services were used. See Exhibit 2 for more details on the use of services for each program.

Most of these telehealth services (about 55,000 in total or 95 percent) were used by claimants in the FECA program. In total, OWCP paid over \$7 million for telehealth services for claimants enrolled in the FECA program, almost 34 times more than the approximately \$209,000 it paid the prior year.

**Exhibit 2: Key Differences in Use of Telehealth Services During and Prior to the COVID-19 Pandemic in the OWCP Programs**

FECA	BLACK LUNG	ENERGY
<p>Almost <b>14,000 claimants, or about 1 in 10</b>, used telehealth services during the pandemic, compared to about 500 claimants in the prior year.</p>	<p><b>237 claimants, or about 3 in 100</b>, used telehealth services during the pandemic. Telehealth was not an allowable service in the prior year.<sup>124</sup></p>	<p>Over <b>1,500 claimants, or about 1 in 10</b>, used telehealth services during the pandemic, compared to 7 claimants in the prior year.</p>
<p>Claimants received <b>about 55,000 services</b> via telehealth during the pandemic, compared to almost 1,700 telehealth services in the prior year.</p>	<p>Claimants received <b>336 services</b> via telehealth during the pandemic. Telehealth was not an allowable service in the prior year.</p>	<p>Claimants received <b>about 2,400 services</b> via telehealth during the pandemic, compared to 10 telehealth services in the prior year.</p>
<p>OWCP paid about <b>\$7 million, or 1% of total medical benefits payments</b>, for telehealth services, compared to about \$209,000 in the prior year.</p>	<p>OWCP paid <b>about \$27,000, or 0.2% of total medical benefit payments</b>. Telehealth was not an allowable service in the prior year.</p>	<p>OWCP paid <b>about \$300,000, or 0.03% of total medical benefit payments</b>, for telehealth services, compared to about \$1,200 in the prior year.</p>

Source: DOL OIG analysis of OWCP telehealth data, 2022.

**OWCP claimants most commonly used telehealth for office visits and behavioral health services.**

Together, these two service types accounted for 93 percent of all telehealth services during the first year of the pandemic. As seen in Exhibit 3, office visits—routine appointments with primary care providers or specialists—accounted for 62 percent of all telehealth services. In addition, behavioral health services accounted for about 31 percent of all telehealth services. Behavioral health services include individual therapy, group therapy, and substance use disorder treatment, among others. Other telehealth services included physical, occupational, and speech therapy, as well as virtual care services, such as telephone calls with a provider or interactions via an online patient portal.



**Exhibit 3: Almost 62 percent** of all telehealth services were office visits, which are routine appointments with a **primary care provider or specialist**.

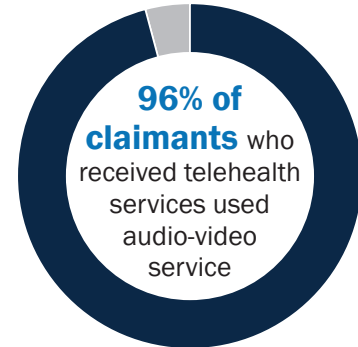
Source: DOL OIG analysis of OWCP telehealth data, 2022.



### **A vast majority of OWCP claimants who received telehealth services used both audio and video telehealth services.**

A total of 669, or 4 percent, of all OWCP claimants who received a telehealth service during the first year of the pandemic, exclusively used one of three covered telehealth services available only via telephone.<sup>125</sup> These three audio-only services include telephone calls with a physician to discuss a beneficiary's medical condition. The vast majority of claimants (96 percent) used audio-video telehealth services. See Exhibit 4.

### **Exhibit 4: Most claimants who received telehealth services used audio-video telehealth services**



Source: DOL OIG analysis of OWCP telehealth data, 2022.

## **PROGRAM INTEGRITY RISKS ASSOCIATED WITH TELEHEALTH**

Officials from all three OWCP programs indicated telehealth was not a significant part of their program services or existing controls mitigated potential integrity issues. However, OWCP found, through its analysis of medical benefit payment data, the following potential program integrity risks associated with telehealth.

### **Program Integrity Risks Related to Payments and Costs**

#### **Telehealth providers may bill for services or supplies that were not rendered.**

OWCP found providers could bill for services that may not have been provided. For example, a provider billed for oral medication and topical products that were supposedly dispensed in person by a physician when a shelter-in-place law was in effect and the claimants were probably not going to the doctor's office. In another instance, the service date of a physician dispensing medication to a claimant in person coincided with the date of a "Zoom" telehealth service.

Another provider billed for services, such as acupuncture, that would need to be performed in an office by a medical professional, during a period when the state was under a mandatory lockdown. The provider indicated in the medical records that monthly evaluations of the claimant were performed through telehealth.

## **Telehealth providers may bill for services that are not necessary.**

OWCP found there was an increase in spending for services such as durable medical equipment attributable to providers that coincided with the move to telehealth services. For example, billing records showed 76 percent of the amount spent in the FECA program on conductive garments for electrical nerve stimulation from October 2019 to September 2020 was attributable to prescriptions written by one provider—with nearly 92 percent spent in 2020. In one case, the provider prescribed the conductive garment for the neck, back, shoulder, knee, and ankle when the accepted medical condition was bilateral Carpal Tunnel Syndrome.<sup>126</sup>

Another provider who prescribed physical therapy for FECA claimants dramatically increased the number of office visits billed after the pandemic began in early 2020. The number increased from 273 office visits billed in February 2020 to over 400 office visits billed in July 2020. Medical reports indicated the office visits occurred via telehealth. The provider saw dozens of claimants multiple times a week, but it was not clear to OWCP why the multiple visits were necessary.

## **Providers could upcode billing.**

Telehealth providers may be using billing codes that reflect more expensive treatments than what was provided to maximize reimbursement. For example, a provider billed a claimant using a billing code for an initial consultation for critical care when the provider actually provided a virtual office visit that was not an initial consultation, nor did it involve critical care.

Another provider treated a claimant twice weekly for 45 to 50 minutes, including phone consultations, but used an inappropriate billing code that represented 60 minutes of psychotherapy instead of a more appropriate 45-minute code.<sup>127</sup> The billing record showed the provider had consistently used the 60-minute billing codes for most of his cases. While there was not a significant difference in the amount paid between the services, the psychologist was the top provider that used this code in the FECA program.

## **Program Integrity Risks Related to Quality of Care and Patient Safety**

### **Providers could treat claimants without required supervision.**

Telehealth providers may be providing medical services to claimants without required supervision. For example, a provider allegedly performed medical evaluations on claimants from a remote location through telehealth using untrained and unsupervised technicians. Another provider, a nurse practitioner, appears to have treated claimants without required physician supervision.

## Program Integrity Risks Related to Needed Data

### **Providers could bill for services provided through telehealth without appropriate billing codes.**

Telehealth providers may be submitting a bill for telehealth services without an appropriate place of service code and/or modifier. OWCP noted that several providers supplied services via telehealth, according to the medical records, but had not used a telehealth modifier when submitting bills.

## Safeguards Against Program Integrity Risks

### **OWCP programs rely on bill payment processing edits and also monitor telehealth data to safeguard against program integrity risks.**

FECA program officials stated they had reviewed telehealth data and, based on the review, established policies and procedures and implemented bill payment processing edits. They also indicated they monitor potential program risks related to telehealth as identified and published by law enforcement and regulatory agencies and as part of their ongoing surveillance protocol. Black Lung program officials stated they review a random sample of medical bills, including bills for telehealth services, as a part of their monthly internal audit process. They also indicated they rely on edits in place to appropriately process bills for telehealth services. Energy program officials stated they are monitoring telehealth utilization frequency against the frequency of in-person services for aligned treatments and refer anomalies for further investigation. Officials from all programs indicated they would reconsider and amend existing controls over telehealth services as program integrity issues are identified.

## ADDITIONAL SAFEGUARDS TO CONSIDER

### **OWCP should consider additional safeguards over data needed to identify telehealth services, such as telehealth modifier codes.**

While telehealth services are not a significant part of the OWCP programs, it is important for OWCP to continue to monitor telehealth services as their use becomes more accepted and widespread. However, in its analysis of medical benefit payment data, OWCP found many of the bills for telehealth services did not include proper telehealth modifier codes. Our analysis of OWCP's telehealth data confirmed that 35 percent of the telehealth services provided during the pandemic lacked telehealth modifier codes. Additionally, officials from the Black Lung program expressed concern that they may not be able to identify and monitor telehealth service-related bills if medical providers are not consistently using the telehealth modifier codes. OWCP should consider developing additional guidance for providers to ensure the modifier codes are appropriately and consistently used on medical bills.

# Department of Justice

## DOJ Prisoner health care services



The DOJ must ensure that federal prisoners in its custody are housed in humane facilities and receive adequate health care.<sup>128</sup> Depending on the location and needs of the individuals in custody, DOJ can serve as either a direct provider or a payer of health services for its prisoners. DOJ prisoner population totals are displayed in Exhibit 1.<sup>129</sup>

**The Federal Bureau of Prisons (BOP):** Most BOP prisoners are housed in BOP-operated prisons (institutions), with smaller subsets of the population housed at privately operated contract prisons and Residential Reentry Centers (RRCs, also known as halfway houses). For prisoners housed in BOP-operated institutions, the BOP provides health care both through clinical staff working inside its institutions and through external health care providers. BOP clinical staff can directly provide health services to BOP prisoners in-person, though in certain situations BOP prisoners may also receive care through internal telehealth visits via remote connection from the institution housing the prisoner to a BOP clinical staff member working at another location.<sup>130</sup> When needed, the BOP can also connect its prisoners with outside medical care, including through telehealth with external providers. The BOP generally uses comprehensive medical services contracts established at individual BOP institutions to facilitate and pay for these external health services.<sup>131</sup> Prisoners in BOP custody have no financial obligation for telehealth care.

**Exhibit 1: DOJ Prisoner Population Totals**

	February 2020	February 2021
BOP-operated Institutions	146,000	124,000
USMS	65,000	64,000

Source: DOJ OIG analysis of DOJ data, 2022.

**The United States Marshals Service (USMS):** The USMS does not directly operate its own detention facilities, nor do USMS staff directly provide medical care to prisoners. Instead, the USMS relies on detention facilities to ensure that the USMS prisoners they house receive medical care. Most USMS prisoners are housed in more than 800 different state and local facilities, under intergovernmental agreements that the USMS arranges with state and local governments. Smaller portions of the USMS prisoner population are assigned to privately operated contract facilities as well as BOP institutions.<sup>132</sup>

Detention facilities, operated by either state and local governments or private contractors, generally

have on-site clinical personnel who provide certain health care services. The cost for these health care services is included in a negotiated rate that the USMS pays the operator of a detention facility to house USMS prisoners. Detention facilities also rely on outside medical providers when inmates require a level of care beyond that which can be provided by on-site clinical personnel. These facilities may select providers from a network established by the USMS National Managed Care Contract contractor. Not only does this contract establish a national medical preferred-provider network, it also provides centralized medical claims processing and payment services for the USMS. After the contractor processes and pays the claim, the USMS then reimburses the National Managed Care Contract contractor.<sup>133</sup> For the subset of USMS prisoners housed in BOP institutions, the BOP is responsible for the costs of all medical care, including telehealth care, these prisoners receive.

**Scope of DOJ Review:** This review describes telehealth services provided to federal prisoners. BOP and USMS telehealth services refer to services that were provided remotely using technology between a provider and a prisoner. This review includes data on telehealth services used by USMS prisoners and by prisoners housed in BOP-operated institutions. The review scope includes telehealth services provided between March 2020 and February 2021 and the year prior. See Appendix F for the DOJ OIG's methodology.

## BOP AND USMS TELEHEALTH PRIOR TO AND DURING THE PANDEMIC

Although the BOP and the USMS had no policies specific to telehealth during the period under review, both DOJ components responsible for the care of federal prisoners utilized telehealth prior to and during the COVID-19 pandemic.<sup>134</sup>

**BOP:** The BOP has utilized telehealth for over two decades and continued to use it during the pandemic. In the year prior to the pandemic, an estimated 91 of the BOP's 122 institutions conducted telehealth visits, based on OIG analysis of available BOP data.<sup>135</sup> Although the BOP does not document the technology used to conduct each telehealth visit in its records, the BOP generally used telephone and video teleconferencing to conduct telehealth, including through BOP-provided mobile telehealth carts equipped with video conferencing and medical device integration capabilities to enable remote consultations. After March 2020, during the first year of the pandemic, an estimated 99 BOP institutions conducted telehealth visits. Between March 2019 and February 2021, an estimated 106 BOP institutions had conducted telehealth visits. The BOP ordered 60 mobile telehealth stations, and by late spring 2021 the BOP's headquarters had shipped 59 of the stations to various BOP institutions.<sup>136</sup> These actions increased telehealth availability at many institutions.

A change the BOP made during the pandemic involved credential verification and granting of clinical privileges or practice agreements for providers. By the end of February 2021, the BOP had issued two waivers during the pandemic of the BOP's credentialing policy requirement for certain telehealth providers to complete the BOP's credential verification and granting of clinical

privileges prior to delivering care to prisoners. In July 2021 and February 2022, the BOP issued additional waivers to its credentialing policy that waived the requirement for institution Wardens to sign clinical privileges or practice agreements and delegated privilege-granting authority for BOP telehealth providers to the BOP Medical Director.<sup>137</sup> The BOP issued these waivers to reduce the administrative burden on its institution staff to process credentialing verifications during the public health emergency while also expanding the pool of available telehealth providers by allowing them additional time and flexibility to fulfill requirements for clinical privileges. Additionally, out-of-state licensure waivers during the pandemic helped facilitate the use of telehealth at BOP institutions.

The BOP reported that the types of telehealth services available to BOP prisoners generally did not change as a result of the pandemic. Additionally, the BOP reported that telehealth service payment rates generally remained constant before and during the course of the pandemic.

**USMS:** USMS officials reported that the USMS permits and encourages the use of telehealth services for its prisoners when available and appropriate, and that the USMS tries to maximize and leverage the use of telehealth when and where possible. However, the USMS could not report which telehealth services were available to USMS prisoners and whether availability changed after the start of the pandemic because the USMS does not maintain a list of services that could be provided using telehealth, or the patients or providers who could use telehealth services. According to our analysis of USMS National Managed Care Contract contractor claims data, the USMS used four telehealth service categories in the year prior to the pandemic, compared to eight telehealth service categories during the first year of the pandemic. Examples of common telehealth services provided to prisoners in USMS custody include office visits, virtual care services, and behavioral health.

The USMS did not report any changes to payment rates for telehealth services after the start of the pandemic and indicated that telehealth services are reimbursed at no greater than the Medicare rate, as required by law.<sup>138</sup> Furthermore, there were no changes to the USMS National Managed Care Contract due to the COVID-19 pandemic.

## TELEHEALTH USE BY THE BOP AND USMS DURING THE PANDEMIC

### **Utilization of telehealth services increased in both the BOP and the USMS during the first year of the pandemic.**

In general, we found that while telehealth use was limited to small fractions of DOJ prisoners when considered in relation to overall populations in custody, telehealth utilization increased for both BOP and USMS prisoners during the first year of the pandemic compared to prior to the pandemic.<sup>139</sup>

During the first year of the pandemic, the proportion of prisoners housed in BOP-operated institutions using telehealth more than doubled compared to the prior year. From March 2020 through February 2021, over 3,900 prisoners in BOP-operated institutions used telehealth services. This figure represents approximately 3.2 percent of the approximately 124,000 prisoners housed in



BOP-operated institutions at the end of February 2021.<sup>140</sup> This is an increase compared to the year prior, when over 1,900 prisoners, or approximately 1.4 percent of approximately 146,000 prisoners housed in BOP-operated institutions, used telehealth.

During the first year of the pandemic, the proportion of USMS prisoners using telehealth increased by a factor of nearly five when compared to the prior year, during which just over 0.1 percent of prisoners used these services. During the first year of the pandemic, from March 2020 to February 2021, over 375 prisoners in USMS custody used a telehealth service.<sup>141</sup> This figure represents just under 0.6 percent of the approximately 64,000 prisoners in USMS custody at the end of February 2021.<sup>142</sup> This is an increase from the year prior, when fewer than 80 prisoners, or approximately 0.1 percent of the approximately 65,000 total prisoners in USMS custody, used telehealth.

Based on available BOP data, prisoners in BOP-operated institutions used approximately 5,300 telehealth services during the pandemic—from March 2020 to February 2021 (see Exhibit 2). This amounts to more than twice as many telehealth services compared to the year prior. As noted in the DOJ OIG’s program integrity section of this report, BOP data limitations resulted in the OIG analyzing incomplete records from two BOP-provided datasets to generate these estimates.

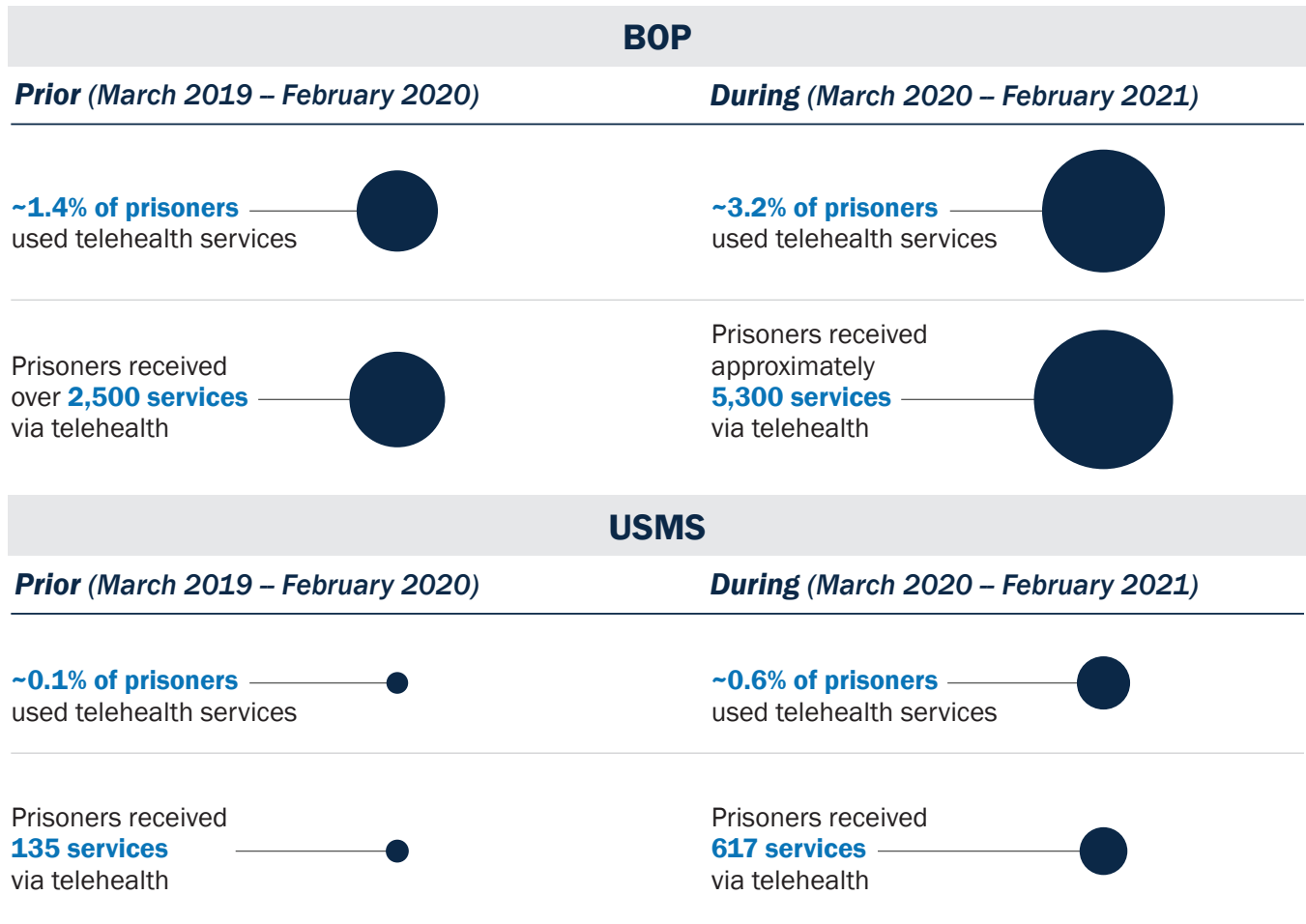
Prisoners in USMS custody used over four times more telehealth services during the first year of the pandemic than during the year prior. Specifically, prisoners in USMS custody used 617 telehealth services during the pandemic, from March 2020 through February 2021.

The BOP estimated that it paid at least \$376,700 for external telehealth services during the first year of the pandemic. We note that this was over 11 times more than what it paid during the year prior; however, there were data limitations affecting the calculation of these cost estimates, which likely under-represent the total costs of external telehealth services.<sup>143</sup> These cost estimates reflect only external telehealth services provided by outside providers at approximately four out of five BOP institutions and do not include the cost of telehealth services delivered by internal BOP providers.<sup>144</sup>

The USMS paid over \$68,000 for telehealth services used by USMS prisoners during the first year of the pandemic, compared to over \$10,100 for telehealth services in the year prior. In total, the USMS paid over six times more during the first year of the pandemic than it paid during the year prior. These cost estimates were generated using selected Current Procedural Terminology (CPT) codes from the USMS National Managed Care Contract contractor claims data.



**Exhibit 2: Key Differences in BOP and USMS Prisoner Use of Telehealth Services Prior to and During the COVID-19 Pandemic**



Source: DOJ OIG analysis of BOP data and USMS National Managed Care Contract contractor claims data, 2022.

Note: As noted in the DOJ OIG’s program integrity section of this report, the BOP figures presented in this exhibit are estimates due to BOP telehealth data limitations.

**Telehealth was used in both the BOP and the USMS for a variety of services.**

For specialty care delivered via telehealth, prisoners housed in BOP-operated institutions most commonly used telehealth for psychiatry, cardiology, nephrology, and gastroenterology visits. Of these telehealth categories, all but psychiatry represented external visits delivered by outside providers only. Together, the four visit types listed above accounted for approximately 68 percent of telehealth visits for specialty care during the first year of the pandemic.<sup>145</sup> Visits for neurology, infectious diseases, and urology accounted for an additional 13 percent of specialty care visits conducted via telehealth. Psychiatry visits with internal BOP providers were the leading type of telehealth visit for specialty care, accounting for 41 percent of specialty care visits.

USMS prisoners most commonly used telehealth for office visits, virtual care services, hospital visits, and behavioral health. Together, these four service types accounted for approximately 95 percent of telehealth visits during the first year of the pandemic. Office visits—routine appointments with primary care providers or specialists—accounted for 55 percent of all telehealth services. Virtual care services, such as telephone calls with a provider or interactions via an online patient portal, accounted for another 18 percent of all telehealth services. Hospital visits, such as professional services provided remotely to patients in an emergency department, or as a part of observation, accounted for 13 percent of all telehealth services. In addition, behavioral health services accounted for about eight percent of all telehealth services. Behavioral health services include individual therapy and substance use disorder treatment, among others. Other telehealth services included nursing home visits, dialysis services, and preventive services.

## PROGRAM INTEGRITY RISKS RELATED TO TELEHEALTH SERVICES IN THE BOP AND THE USMS

The changes in telehealth usage for prisoners in BOP and USMS custody, along with limited available telehealth data and a lack of BOP and USMS telehealth policies, underscore the importance of determining whether providers are billing for telehealth services appropriately, as well as identifying ways to safeguard the programs and ensure quality of care.

### Current Program Integrity Safeguards Used by the BOP and the USMS

The BOP and the USMS do not have safeguards specifically designed for telehealth, and instead rely on safeguards that are in place for all medical services. Both the BOP and the USMS have certain procedures to verify the accuracy of claims submitted for outside medical care provided to prisoners in their custody, which also apply to claims for telehealth services.

**BOP:** The BOP has protocols established for the submission and approval of medical claims for outside medical care provided to prisoners in BOP custody. The BOP requires that each institution have a medical claims adjudication process to ensure that services billed by the contractor were properly authorized and ordered by the institution, are appropriately coded in compliance with Medicare coding policies (as applicable), are properly priced in accordance with terms and conditions of the contract, and do not represent duplicate billings for payments already made. A medical claims adjudicator determines the validity of the CPT codes and other data listed in the claims to verify the accuracy of claims submissions.

**USMS:** The USMS National Managed Care Contract's performance work statement requires the National Managed Care Contract contractor to establish an anti-fraud program. This program provides oversight of health care providers that identifies unusual patterns of care, over-utilization of services, suspected billing practices, and other unusual patterns. In addition, USMS district offices review and certify the bill of National Managed Care Contract contractor claims every month before USMS headquarters reimburses the contractor for claims for services provided.

## Advantages of Telehealth for Individuals in Federal Custody

Personnel from the BOP and the USMS described several advantages of having telehealth as an option in their custodial environments, both before and during the pandemic. Telehealth as a mechanism of care allows for care of prisoners while they remain inside secure institutions. This model for addressing certain health care needs mitigates safety risks when prisoners are removed from secure custodial environments and transported to community settings for outside medical care. Both BOP and USMS officials expressed views that telehealth was an option that offered benefits to community safety.

Telehealth can also help promote continuity of care and access to care for this patient population. For example, BOP providers working at institutions may help facilitate telehealth visits with outside providers and share relevant prisoner medical information during the telehealth visit. Further, given that many custodial institutions are in isolated locations, telehealth can serve as an option that increases access to health care providers with necessary expertise. For example, at one USMS contract detention facility that utilized telehealth during the pandemic, facility personnel explained that telehealth afforded prisoners increased access to quality providers, especially given the facility's remote location.

Additionally, both BOP and USMS officials noted that use of telehealth instead of outside medical trips could present cost savings for their health care programs, particularly given that outside care generally requires personnel to transport prisoners to outside medical facilities. Personnel at one BOP Federal Medical Center told the DOJ OIG that telehealth was cost-effective compared to outside medical trips for routine care, which represented significant expenses for the institution.<sup>146</sup>

During the COVID-19 pandemic, telehealth provided the additional benefit of helping mitigate the risk of COVID-19 transmission by limiting the potential for prisoners and staff to contract or introduce COVID-19 in settings outside the custodial environment. As described by USMS-contracted detention facility staff, telehealth generally reduced facility staff and prisoner exposure to COVID-19, as telehealth limited the need to transport prisoners into the community for outside health care.

## Program Integrity Risks Related to Billing

Both the BOP and the USMS reimburse external providers for telehealth services delivered to prisoners in their custody. The BOP's historical challenges to oversee costs for outside medical care, in addition to the BOP's lack of full visibility into total telehealth costs, may present program integrity risks for telehealth.

**BOP: Prior DOJ OIG work has identified concerns regarding the BOP’s potential overpayment for outside medical services and the BOP’s ability to identify fraudulent billing schemes.**

The BOP’s method for reimbursement of claims for telehealth services delivered by outside providers is the same as that for other types of outside medical care. Although the DOJ OIG did not assess payment risks specific to telehealth services, previous DOJ OIG audit work has found that the BOP had limited oversight of contract costs billed and paid related to medical billings by contractors responsible for the provision of medical services at BOP institutions. For example, a 2019 DOJ OIG audit of a BOP-awarded comprehensive medical services contract for services provided to a BOP-operated institution identified weaknesses in the contract related to the definition of contract requirements and establishment of contract pricing methodology, as well as instances in which contractor performance did not comply with contract terms, resulting in the BOP paying the contractor over \$825,000 for out-of-network services and services not covered by Medicare pricing without proper approval of the prices billed.<sup>147</sup> Further, the DOJ OIG issued a February 2022 Management Advisory Memorandum which found that the BOP potentially overpaid for medical services provided to prisoners (see the text box).<sup>148</sup>

**Concerns Regarding Potential Overpayment by BOP for Prisoner Health Care Services**

In February 2022, DOJ OIG issued a Management Advisory Memorandum which identified that at least one prime Comprehensive Medical Services Contractor sometimes selected and submitted to the BOP medical service billing codes on behalf of its subcontracted providers of medical services, instead of having the providers select such codes themselves. This approach is inconsistent with the approach typically used in traditional medical practices. The DOJ OIG’s investigation into this issue revealed that, when this Comprehensive Medical Services Contractor selected the codes for its subcontracted health care providers, in almost every instance the selected code represented the highest level, or costliest, in the applicable series. By contrast, when the subcontractor health care provider selected the code, in the overwhelming number of cases, the subcontractor did not select the highest level in the applicable series. The DOJ OIG concluded that this resulted in the BOP potentially overpaying for medical services provided to prisoners.

The BOP’s challenges with its medical claim record maintenance could also raise program integrity risks for telehealth, as the BOP lacks a national medical claims system capable of centrally tracking total telehealth care costs across its 122 institutions. In December 2017, DOJ OIG issued a Procedural Reform Recommendation for the BOP regarding the BOP’s incomplete health care claims, which the BOP remained unable to fully close as of May 2022.<sup>149</sup> The DOJ OIG found that the BOP’s health care claims continued to be processed primarily through manual methods. Further, DOJ OIG has found that the deficiencies with the BOP’s health care claims data limited the BOP’s and other stakeholders’ ability to identify and respond to potentially fraudulent billing schemes such as claims for services not rendered, duplicate claims, or inflated bills. As of May 2022, the BOP had not yet fully implemented the DOJ OIG’s recommendation to ensure that its adjudication vendor is able to reproduce on demand all necessary data elements used to adjudicate the claims and to ensure that the universe of claims data is available to the BOP on a national scale in a format that allows for thorough analysis and oversight.<sup>150</sup> According to the

BOP, as of May 2022, the BOP has awarded a medical claims adjudicator contract that requires the vendor to describe and submit surveillance programs for detection and tracking of potential fraud and abuse. The BOP further noted that such programs shall include real-time capabilities for research, reporting, and alerts to identify potential fraud and abuse. Lastly, the BOP would be contacted immediately upon the identification of fraud and abuse and receive a detailed report of the findings. The current lack of a central claims system to track costs could present risks for telehealth program integrity.

### **USMS: The National Managed Care Contract contractor maintains an anti-fraud program on behalf of the USMS.**

As discussed above, the USMS's National Managed Care Contractor processes and pays claims for prisoner telehealth care procured through outside medical providers. For this review, the DOJ OIG did not assess the efficacy of the anti-fraud program, nor did we independently assess claims data to determine fraud risks unique to the provision of telehealth care.

### **Quality of Care and Patient Safety**

The BOP's and the USMS's insights into quality of care and patient safety for DOJ prisoners using telehealth may be limited. The lack of telehealth specific policies and comprehensive telehealth data for prisoners in DOJ custody could present risks to ensuring quality of care and patient safety. Further, OIG analysis of available BOP telehealth data identified two potential areas of concern.

### **BOP: Although the BOP's electronic health record system tracks referrals to specialists, prior DOJ OIG work has identified challenges with the BOP's ability to assess medical care delivered by outside providers.**

The lack of BOP telehealth policies and robust telehealth data could present barriers to the BOP's ability to assess the quality of its telehealth care. Further, prior DOJ OIG audit work has identified issues with the BOP's ability to assess comprehensive medical services contractor performance related to the timely delivery of prisoner health care and quality of care. For example, a March 2022 audit of comprehensive medical services contracts awarded by the BOP found that the BOP did not have a reliable, consistent process in place to evaluate either the timeliness of prisoner health care or the quality of that care at several BOP institutions.<sup>151</sup> According to the BOP, its Bureau Electronic Medical Record (BEMR) system allows the BOP to review referrals to specialists and track scheduling dates and other information.

### **Based on available BOP telehealth data for specialty care, the DOJ OIG identified two potential risk areas that could potentially raise continuity of care concerns.**

First, the DOJ OIG identified challenges with the BOP's ability to schedule some telehealth visits for specialty care within the timeframe that BOP personnel requested. Specifically, according to

BOP-provided consultation request data, while 71 percent of specialty care telehealth visits occurred no later than 1 week after the requested target date, 29 percent occurred more than a week after the requested target date. Although most telehealth visits, or 85 percent, occurred no more than 30 days after the scheduled target date, we found it concerning that 183 telehealth visits appeared to have occurred over 3 months after the scheduled target date, including one visit that occurred nearly 1 year after the target date, according to BOP records. Delays in scheduling telehealth visits could potentially interfere with prisoners' prompt access to telehealth care.

Second, the DOJ OIG identified some delays in the BOP's entry of telehealth visit results into its BEMR system. Although the BOP generally updated most of these records promptly (same day for almost half of telehealth visits and within 1 week for 84 percent of visits), for a small subset (1 percent) of telehealth visits, records were not updated for over a month. We identified some concerning outliers for which it took the BOP more than 100 days to enter telehealth visit results into BEMR for eight telehealth visits, including one visit for which it took the BOP 1 year to enter the results into BEMR. Delays entering telehealth visit results into records could pose potential challenges to ongoing BOP prisoner care.

### **USMS: The USMS's lack of telehealth policies and comprehensive telehealth data could pose quality of care oversight challenges.**

With over 800 intergovernmental agreement facilities, in addition to multiple contract and BOP facilities that house USMS prisoners, there is a significant variety of settings in which telehealth services may be available to USMS prisoners nationwide. The lack of comprehensive telehealth data and policies at the USMS, coupled with the USMS's limited insight regarding telehealth services available to USMS prisoners, even as telehealth usage has increased, could present risks to the USMS's ability to assess quality of care for telehealth services.

### **Additional Data Needed for Effective Program Management and Oversight**

We found that both the BOP and the USMS have blind spots in available data that affect their ability to gather a full picture of telehealth for prisoners in federal custody. Given the increases to telehealth utilization since the start of the pandemic, it is increasingly important for DOJ officials to have reliable information on the scope and costs of these programs. Further, given the potential benefits of the use of telehealth to meet certain health care needs for prisoners, more complete and reliable data on these programs is necessary.

### **BOP: Data limitations make it difficult for the BOP to track the number of telehealth visits for prisoners in BOP custody and associated telehealth costs.**

The BOP lacks a reliable method to calculate total BOP telehealth costs. Due to the lack of a central claims system that would facilitate calculations of total telehealth costs, and the variety of comprehensive medical services contracts established across the BOP's 122 institutions, the



BOP's cost estimates do not account for telehealth costs incurred at nearly one-fifth of its facilities. Additionally, available BOP telehealth utilization data does not contain cost information. Thus, the BOP lacks a centralized and comprehensive picture of the costs associated with its use of telehealth services.

In addition to the lack of definitive insight into telehealth costs, limitations associated with the BOP's BEMR system do not allow the BOP to identify and report the complete number of telehealth visits with prisoners in BOP custody. The quality of data available depends on each BOP institution accurately and timely recording telehealth visits in BEMR. Further, the BOP was unable to provide a comprehensive and unduplicated dataset that would definitively capture the number of telehealth visits with prisoners in the facilities it operates. The BOP also advised that it could not definitively tell whether records from two potentially relevant datasets represented patient-to-provider telehealth visits or asynchronous patient notes without completing individual chart reviews for each record, which the BOP stated was not feasible. Limitations with BEMR limit the BOP's visibility into the number of prisoner-to-provider telehealth visits across its institutions. Further, one of the telehealth datasets provided by the BOP does not provide insight into specific categories of care for which the BOP uses telehealth to treat prisoners.

### **USMS: The USMS lacks comprehensive telehealth data and available data may not account for all telehealth visits.**

During our review we learned that at least one USMS detention facility contractor provides telehealth care as an in-house service. This operator does not submit a claim for any in-house telehealth care because, as described above, the costs of any in-house health care services (whether virtual or in-person) are included in a negotiated rate that the USMS pays the detention facility operator. Without separate data detailing in-house telehealth clinical encounters, the USMS could not tell us the total number of in-house telehealth clinical encounters involving USMS prisoners or the total number of prisoners that received care as an in-house service at this facility.

Further, USMS officials acknowledged that they do not know how many facilities offer telehealth care as an in-house service. Without an understanding of how many facilities are providing telehealth as an in-house service, as well as how many of the in-house services provided at these facilities are conducted virtually, the USMS does not know the total number of its prisoners that have received telehealth care.

### **The BOP and USMS also lack data regarding the number of prisoners who used audio-only telehealth services.**

Neither the BOP nor the USMS maintains data that distinguishes the number of prisoners who used telehealth services using audio-only services compared to audio-video telehealth.



## NEEDED PROGRAM INTEGRITY SAFEGUARDS

Additional research is needed to assess the efficacy of telehealth services for prisoners in DOJ custody. A significant challenge that we identified to the transparent and effective implementation of telehealth in DOJ prisoner health care services centered on the lack of complete and reliable data on these types of clinical encounters with individuals in custody. As discussed above, the BOP's telehealth data is limited and the USMS does not maintain complete information about which USMS prisoners have access to telehealth care. Although both components reported that they were working to enhance their recordkeeping in this area, these gaps in relevant data limit the DOJ components' ability to assess the utilization, appropriateness, cost-effectiveness, and efficacy of telehealth in their programs. We believe that the BOP and the USMS should strengthen their collection of telehealth data and conduct additional research to inform their use of telehealth and safeguard program integrity for telehealth services provided to prisoners in their custody.

# APPENDIX A: Department of Health and Human Services Medicare



## METHODOLOGY

**Scope |** This review describes Medicare telehealth services provided by physicians and non-physician practitioners during the first year of the pandemic (i.e., from March 2020 through February 2021) and the year prior (i.e., from March 2019 through February 2020).<sup>152</sup>

**Data Sources |** The HHS OIG's review included multiple data sources, including policies, regulations, and statutes related to coverage of telehealth in Medicare; Medicare fee-for-service claims and Medicare Advantage encounter data; HHS OIG hotline complaints; an interview with CMS staff about program integrity efforts and a review of related CMS documentation; and a review of ongoing and previous OIG work.

**Nature and Use of Telehealth in Medicare |** To describe the nature of telehealth during the first year of the pandemic and the year prior, the HHS OIG reviewed relevant policies, regulations, and statutes and identified differences related to services, beneficiaries, providers, and payment rates between the two time periods.

In addition, the HHS OIG conducted analyses of claims and encounter data to determine the extent to which Medicare beneficiaries used telehealth during the first year of the pandemic and the year prior.<sup>153</sup> To do this, we identified the services that Medicare approved for telehealth during the pandemic, using Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes.<sup>154</sup> We then identified claims and encounter data billed with these CPT and HCPCS codes that had a modifier (i.e., 95, GT, GQ, or GO) or a "place of service code" (i.e., 02) that indicates the service was delivered via telehealth.<sup>155</sup>

Using these data, we determined the number of beneficiaries who used telehealth services and the total number of telehealth services they used during the first year of the pandemic and the year prior. We also calculated the total amount paid by Medicare for telehealth services. Payment amounts are for beneficiaries in Medicare fee-for-service only; payment amounts are unavailable in the Medicare Advantage encounter data.

To determine the most common telehealth services, we grouped each service into a category based on CMS's service classification system and CPT codes and calculated the number of telehealth services in each category.

To determine the number of beneficiaries who used audio-only telehealth services, we focused on the six telehealth services that are available exclusively audio-only. These six audio-only services do not include video; they consist of telephone calls with a provider for various durations to discuss a beneficiary's medical condition. We did not include the other telehealth services that can be provided audio-only because it was not possible to distinguish whether they were provided audio-only or audio-video.

To determine the proportion of beneficiaries who received telehealth services only from providers with whom they had an established relationship, we reviewed Medicare fee-for-service claims and Medicare Advantage encounter data for telehealth services provided from March 2020 through December 2020. We then determined if a beneficiary had an established relationship with a provider by identifying the date of the first telehealth service with the provider and looking back to January 2018 to determine if the beneficiary had a prior in-person visit or other service with that same provider.<sup>156</sup>

**Program Integrity Risks Associated with Telehealth** | To describe the program integrity risks associated with telehealth, we developed seven measures as indicators of possible fraud, waste, or abuse. We developed these measures based on analyses of Medicare data and input from OIG investigators. These measures focus on different types of billing schemes for telehealth that providers may use to maximize their Medicare payments. For each measure, we set thresholds at extreme levels that may indicate possible fraud, waste, or abuse. We then analyzed Medicare fee-for-service claims and Medicare Advantage encounter data for the first year of the pandemic and identified providers whose billing exceeded the threshold on at least one of the seven measures. These providers had billing that poses a high risk to Medicare.<sup>157</sup>

To further identify potential program integrity risks, we reviewed complaints made to the HHS OIG hotline. We reviewed the complaints related to telehealth made during the first year of the pandemic and described the nature of these complaints.

We also interviewed CMS staff and reviewed CMS documentation about the safeguards they have in place to prevent fraud, waste, and abuse related to telehealth.

Lastly, we reviewed ongoing and previous OIG work—including investigations—related to telehealth to identify program integrity concerns, focusing on those related to billing, quality of care, and data. We also identified recommendations that OIG has made to CMS related to program integrity.

## Limitations

None of the measures or hotline complaints that we analyzed confirm that a particular provider is engaging in fraudulent or abusive practices. Any determination of fraud or an overpayment would require additional investigation.

## Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

# APPENDIX B:

## Department of Defense

# TRICARE



## METHODOLOGY

**Scope |** The DoD OIG evaluation describes telehealth services delivered through the TRICARE East and West preferred provider networks in the continental United States. The evaluation covers the first year of the COVID-19 pandemic (March 2020–February 2021) and the prior year (March 2019–February 2020).

**Data Sources |** The DoD OIG’s evaluation used multiple data sources, including,

- DoD TRICARE Operation, Policy, and Reimbursement Manuals;
- DoD TRICARE governing and regulatory authorities;
- previous DoD OIG telehealth audit work;
- a DHA telehealth encounter summary report; and
- a summary of TRICARE private sector beneficiaries enrolled in the Prime and Select health care plans.<sup>158</sup>

In addition, we interviewed DHA officials regarding their program integrity oversight activities related to telehealth. We excluded TRICARE for Life telehealth claims from our review because the Centers for Medicare & Medicaid Services is the payer of first resort. Therefore, these telehealth claims would be double-counted.

**Nature and Use of Telehealth in TRICARE |** To understand the nature of telehealth during the first year of the pandemic and the prior year, we reviewed DHA TRICARE policy manuals. This information helped us identify important changes in telehealth policy for patients, providers, and services. We also reviewed a DHA summary of telehealth claims data covering TRICARE private sector beneficiaries enrolled in the Prime and Select health care plans.

In addition, using these data, we determined the number of beneficiaries who used private sector telehealth services and the total number of telehealth services they used during the first year of the pandemic and the prior year. We also calculated the total amount paid by TRICARE for telehealth services for each 1-year period.

**Program Integrity Risks Associated with Telehealth** | To describe the program integrity risks associated with telehealth, we reviewed the DoD TRICARE Operations Manual, DoD TRICARE Policy Manual, and 32 Code of Federal Regulations part 199, and interviewed DHA program integrity officials. We also reviewed a DHA contractor oversight survey summary report. In addition, we reviewed the 2020 DHA “Program Integrity Division Operational Report” and DHA’s response to our data request regarding telehealth safeguards in place to prevent fraud, waste, and abuse. Finally, we reviewed a prior DoD OIG audit report that focused on telehealth payment program integrity.<sup>159</sup>

## LIMITATIONS

To provide timely information, we did not test the reliability of the TRICARE enrollment and funding totals provided by DHA officials. However, to ensure the accuracy of the TRICARE enrollment and funding totals, we reviewed the TRICARE Policy Manual and established telehealth claims parameters in our request to the DHA. We determined that the TRICARE enrollment and funding totals provided by the DHA were sufficient for the purpose of our review. We reviewed DHA policy covering TRICARE Program integrity controls. However, we did not test the program integrity controls.

Additionally, DHA officials were not able to identify telehealth related issues on billing and payment for services not provided or not medically necessary due to their restricted access to medical records. The restriction from access to medical records also limited the DHA’s ability to identify issues with higher level of service or length of service than what the practitioner provided or was necessary, ordering medically unnecessary laboratory tests, durable medical equipment, or prescription drugs. Due to the restrictions on medical record access, the DHA conducts audits of claim data disassociated with medical records, and this limitation can only result in identifying over-utilization of billing codes or hours exceeding a 12-hour day.

## STANDARDS

The DoD OIG conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

# APPENDIX C:

## Office of Personnel Management

# Federal Employees Health Benefits Program



## METHODOLOGY

**Scope |** This review describes Federal Employees Health Benefits Program (FEHBP) telehealth services provided by physicians and non-physician practitioners during the first year of the pandemic (i.e., from March 2020 through February 2021), the year prior (i.e., from March 2019 through February 2020), and the extended pandemic period (i.e., from March 2021 through December 2021).<sup>160</sup>

**Data sources |** OPM OIG reviewed multiple data sources applicable to all FEHBP health insurance carriers (carriers), including: OPM Healthcare and Insurance (HI) office's FEHBP Carrier Letters; the Coronavirus Aid, Relief, and Economic Security Act (CARES Act); the Families First Coronavirus Response Act (FFCRA); and the FEHBP Enrollment and Headcount Report. In addition, OPM OIG reviewed claims data for one carrier from our claims data warehouse as well as responses to an OIG telehealth survey sent to a selection of ten FEHBP carriers.

**Nature and Use of Telehealth in the FEHBP |** To understand the nature of telehealth services during the first year of the pandemic and the year prior, OPM OIG reviewed relevant OPM HI Carrier Letters to understand OPM HI's telehealth guidance to FEHBP carriers. While OPM did issue some general guidance, OPM itself does not set policies regarding the administration of telehealth in the FEHBP. Rather, procedures are decided upon by each carrier, or in some cases, by individual providers. Therefore, we also reviewed the CARES Act; the FFCRA; the Department of Health and Human Services (HHS) Fourth Amendment to the Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 and its republication; and the HHS Office for Civil Rights Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency to gain a better understanding of telehealth policies overall.

We also reviewed responses to a carrier survey in which we selected ten FEHBP carriers of varying plan types and sizes, covering a large portion of the FEHBP member population, to understand how carriers managed telehealth services, including but not limited to benefit coverage and exclusions, claims processing and payments, and security and privacy concerns.



Furthermore, we analyzed health insurance claims data from one large fee-for-service carrier to identify trends, patterns, and/or concerns of interest. This carrier covers approximately 68 percent of the FEHBP member population. We used Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes, modifier codes (i.e., 95, GT, GQ, or GO), or a “place of service code” (i.e., 02) to identify claims for services delivered via telehealth.<sup>161</sup>

Using this data, we determined the number of members from one large carrier who used telehealth services and the total number of telehealth services they used during the first year of the pandemic, the year prior, and throughout the rest of 2021. We also calculated the total amount paid by this carrier for these telehealth services.

To determine the most common telehealth services, we grouped each service into a category based on the CMS Restructured BETOS Classification System (RBCS Taxonomy)<sup>162</sup> and the CPT/HCPCS codes in our claims data. After creating these groupings, we calculated the number of telehealth services in each category.

To determine the proportion of members who received telehealth services from providers with whom they had an established relationship, we reviewed FEHBP claims data for telehealth services provided from March 2019 through December 2021. The carrier data we reviewed utilizes a specific plan code to identify claims obtained through its contracted telehealth company’s portal (as opposed to a local provider portal). All claims for this plan code were considered instances where the member would not have had a prior relationship with this provider, because this telehealth company’s portal assigns a physician to the patient at the time of service. This is in contrast to a telehealth appointment scheduled through a local provider portal, which would be scheduled with a member’s provider of choice, the same way as in-person appointments are scheduled.

**Program Integrity Risks Associated with Telehealth |** To describe the program integrity risks associated with telehealth, we developed six measures as indicators of possible fraud, waste, or abuse. We developed these measures based on analyses of FEHBP claims data and input from OIG investigators. These measures focus on different types of billing schemes for telehealth that providers may use to maximize their FEHBP payments. For each measure, we set thresholds at extreme levels that may indicate possible fraud, waste, or abuse. We then analyzed FEHBP fee-for-service claims for the time periods specified in our scope above (dependent on the measure) and identified providers whose billing exceeded the threshold on at least one of the six measures. These providers had billing that poses a high risk to the FEHBP.

To further identify potential FEHBP integrity risks, we reviewed complaints made to the OPM OIG fraud, waste, and abuse hotline. We reviewed all complaints related to telehealth and ultimately did not identify any further risk measures from this review.

We also asked questions in our above-mentioned carrier survey regarding the safeguards carriers have in place to prevent fraud, waste, and abuse related to telehealth.

## LIMITATIONS

None of the measures that we analyzed confirm that a particular provider is engaging in fraudulent or abusive practices. Any determination of fraud or an overpayment would require additional investigation.

## STANDARDS

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

# APPENDIX D: Department of Veterans Affairs Veterans Health Administration



## METHODOLOGY

**Scope of analysis of telehealth services provided by VA providers |** The time frames for our review of telehealth services provided by VA providers are the year before the COVID-19 pandemic, March 2019 through February 2020, and the first year of the COVID-19 pandemic, March 2020 through February 2021. We did not include telehealth consultations between providers because this type of care does not include real-time interaction with a patient. In addition, we did not include VA's remote monitoring home telehealth program, which provides remote case management services for chronic health conditions.

We used the VHA Corporate Data Warehouse as the source for health care encounter data. Telehealth encounters were identified by stop codes, as VHA defines telehealth encounters using stop codes rather than CPT codes. Stop code is a VHA term used to characterize outpatient clinical encounters. Modalities of care may include in-person, telephone, and video telehealth.<sup>163</sup> We reviewed VHA's list of stop codes and included those that indicated a synchronous encounter between a provider and patient. Stop codes for group clinics were excluded. The included stop codes were designated as primary care, behavioral health care, specialty care, or other ancillary services for the purposes of reporting data for this report.

We are not able to report on the cost of telehealth provided by VA facilities at the time of this review. Funds are allocated to VA medical centers based on workload, which incorporates the volume of patients served and the complexity of care that is delivered. Fund allocation is based on previous years' data.

**Scope of analysis of telehealth services provided in community care |** For our review of community care telehealth, we analyzed claims data from VA's claims processing systems—Plexis and CCRS. Our time scope was March 1, 2019, through December 31, 2021. We first identified all claims that were paid and that were for professional care. Then, we analyzed claims that included one or more of the following types of codes: (1) a telehealth modifier, (2) telehealth CPT code, or (3) place of service code indicating telehealth, to identify claims for telehealth that veterans received from community providers.<sup>164</sup>

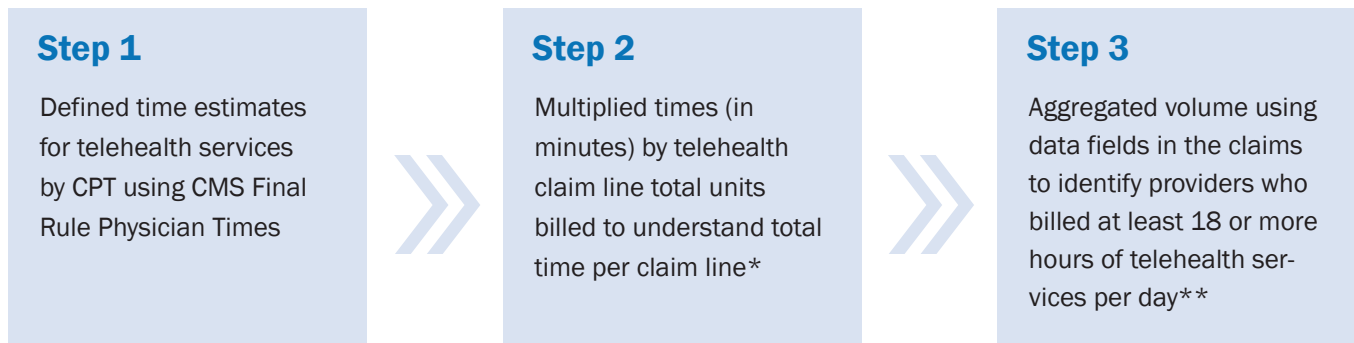
Finally, we grouped these claims by Berenson-Eggers Type of Service (BETOS) codes. These codes are assigned for each Healthcare Common Procedure Coding System (HCPCS) code and were developed for analyzing the growth in Medicare expenditures. Each HCPCS code was assigned to only one BETOS code.

**Telehealth Program Integrity Testing |** To identify schemes for telehealth that could potentially pose a high risk to VA, we developed testing strategies to indicate possible fraud, waste, or abuse. We developed these strategies by analyzing community telehealth claims data, considering fraud indicators applicable to the work, and consulting with VA OIG investigators.

First, we compared VA’s paid community care telehealth claims data and the CMS list of telehealth services to identify the volume of ineligible telehealth services that VA paid for during the review period. From this comparison, we identified ineligible claims as those with CPT codes that were not on this list or did not occur within the time frames provided by CMS, and were not telehealth CPT codes.

Second, we identified high-usage days. Exhibit 1 shows how we identified high-usage days.

**Exhibit 1. Identifying High-Usage Days**



Source: VA OIG analysis of VA community care telehealth claims data as of December 2021.

\*We excluded any claims with payments per unit that were less than \$1.

\*\*We used the RENDERINGPROVIDERID and SERVICE DATE TO data fields.

Third, we identified high-intensity evaluation and management telehealth claims. The number of these claims, and the number of providers with one or more such claims, were then calculated as percentages of the total number of telehealth claims and providers, as described in Exhibit 2.

## Exhibit 2. Identifying High-Intensity Evaluation and Management Telehealth Claims



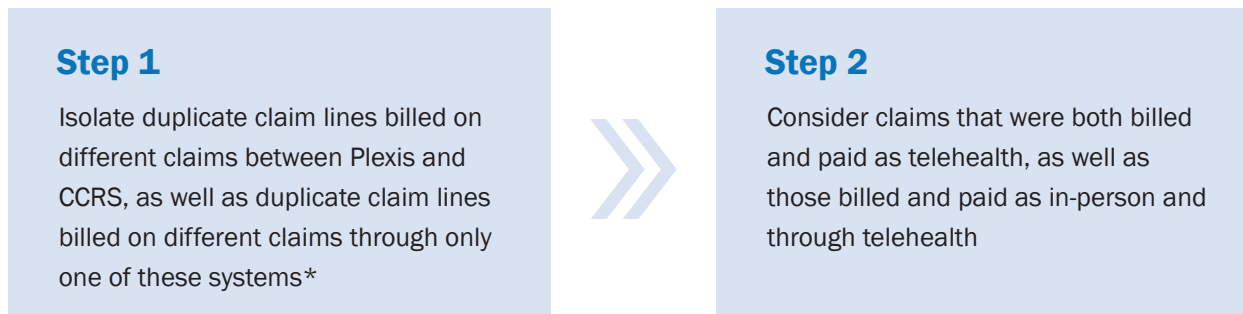
Source: VA OIG analysis of VA community care telehealth claims data as of December 2021.

\* We used the PROCCODE fields 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215.

\*\*We included providers with at least one high intensity claim using the RENDERINGPROVIDERID and CLAIMID fields.

Finally, we took steps to identify potentially duplicate services, as seen in Exhibit 3.

## Exhibit 3. Identifying Potentially Duplicate Services



Source: VA OIG analysis of VA community care telehealth claims data as of December 2021.

\* We looked for claims with different values in the CLAIMID field with the same values for veteran social security number (BOX1A), community provider (RENDERINGPROVIDERID), date of service (SERVICE DATE TO, BOX24ATO), and CPT code (PROCCODE, BOX24DCPT).

**VA's Digital Divide Program Integrity Testing |** We leveraged existing work that assessed VA's digital divide program and specifically examined the consult workflow at VA medical facilities during FY 2021, including the percentage of patients who completed a VVC appointment.<sup>165</sup>

We interviewed key officials from Connected Care who were primarily responsible for the digital divide program and conducted virtual site visits with five regional network leads and staff from the eight facilities in the sample. The site visits were to ascertain digital divide processes and procedures, determine the national program office's effectiveness at disseminating guidance, and identify potential internal control gaps in the consult guidance and device management. The sample review findings were discussed with VA medical facility staff to confirm the identified issues and establish their causes.

We also analyzed VA-loaned device activity data from VA's tablet dashboard to determine if each patient who received a device in the period of review completed a VVC appointment or had one scheduled. Interviews with telehealth coordinators at eight medical facilities helped us identify

the controls in place for device issuance, monitoring, and return. We also conducted a site visit and interviews with Connected Care officials and contractor and other VA staff to understand the purchasing, refurbishment, and inventory processes.

**Data Reliability** | We took steps to assess the reliability of the data we used to report on VA's use of telehealth services and devices during the pandemic. We performed limited testing of the data and found that they were sufficiently reliable for the purpose of this report.

## STANDARDS

The VA OIG conducted this work in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

# APPENDIX E:

## Department of Labor

# Office of Workers' Compensation Programs



## METHODOLOGY

**Scope |** DOL OIG evaluated telehealth services provided to claimants in OWCP's FECA, Black Lung, and Energy Programs during the pre-pandemic period (March 1, 2019, to February 29, 2020) and the pandemic period (March 1, 2020, to February 28, 2021). OWCP does not maintain telehealth data on benefits paid by self-insured employers or insurance carriers; therefore, this report does not include data on the Longshore program, whose benefits are primarily provided by employers or insurance carriers. Likewise, this report only covers services provided by the Black Lung program that were paid out of the Black Lung Disability Trust Fund. Additionally, we excluded telehealth services that did not reflect an interaction between a claimant and a provider to ensure consistency with the PRAC's definition of telehealth used for this report.<sup>166</sup>

**Data sources |** OWCP extracted telehealth services data from its Workers' Compensation Medical Bill Process (WCMBP) system using the following attributes to identify telehealth services:

- FECA program: place of service, telehealth modifier, provider type, and procedure code.
- Black Lung program: telehealth modifier and procedure code.
- Energy program: telehealth modifier and procedure code.

DOL OIG reviewed OWCP's program policies and procedures, obtained information via interviews and questionnaires, analyzed OWCP data, and reviewed OWCP referrals to OIG investigators.

Because OWCP lacked sufficient oversight processes and documentation to support controls over the WCMBP system,<sup>167</sup> we were unable to determine the overall reliability of the medical bill payment data in the system. However, we performed procedures such as data testing for accuracy and completeness and performed reconciliations of the telehealth services data. We determined the data was sufficiently reliable for the purposes of this evaluation.

**Number and types of telehealth services |** DOL OIG used procedure codes, dates of service information, and HHS OIG's telehealth service categories to determine the number and types of telehealth services provided during the pandemic and pre-pandemic periods.



**Number of claimants receiving telehealth services |** DOL OIG used OWCP’s case numbers and dates of service information to identify the distinct number of claimants who received telehealth services during the pandemic and pre-pandemic periods.

**Cost of telehealth services |** DOL OIG calculated the cost of telehealth services during the pandemic and pre-pandemic periods by using the amount paid by OWCP and the date of service.

## LIMITATIONS

DOL OIG did not obtain units of service data, but counted the number of procedures billed to determine the number of telehealth services provided to claimants. Consequently, the actual number of individual services provided could be higher.

## STANDARDS

DOL OIG conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by Council of the Inspectors General on Integrity and Efficiency.

# APPENDIX F:

## Department of Justice

# DOJ Prisoner health care services



## METHODOLOGY

**Scope |** The review describes telehealth services provided to prisoners in the custody of the Bureau of Prisons (BOP) and United States Marshals Service (USMS) during the first year of the COVID-19 pandemic (March 2020 through February 2021) and the year prior (March 2019 to February 2020).

**Data sources |** The DOJ OIG's review included multiple data sources, including: BOP and USMS policies, guidance, and memoranda; BOP waivers; BOP and USMS documentation and written responses to OIG requests; contract documentation related to the USMS's National Managed Care Contract and a privately operated USMS contract detention facility; statutes related to payments for costs of health care services for prisoners in USMS custody and the collection of fees from federal prisoners for health care services; interviews with BOP Central Office staff, BOP institution staff, USMS Headquarters staff, USMS contract detention facility staff, USMS National Managed Care Contract staff, and a USMS Detention Contract Manager; the BOP's BEMR consultation request data and clinical encounter note data; USMS National Managed Care Contract contractor medical claims data; BOP-provided cost-estimate data generated by BOP comprehensive medical service contractors; DOJ OIG hotline complaints; BOP public website population data; and a review of previous OIG work.

**Nature and Use of Telehealth in the BOP and the USMS |** To describe the nature of telehealth for prisoners in BOP and USMS custody during the first year of the pandemic and the year prior, DOJ OIG reviewed relevant policies, guidance, memoranda, waivers, statutes, and documentation provided by the BOP and the USMS. The DOJ OIG also conducted interviews of BOP and USMS staff, in addition to USMS contract detention facility staff and USMS National Managed Care Contract staff to inform this report section.

In addition, DOJ OIG conducted analyses of BOP-provided BEMR consultation request data and clinical encounter note data with selected telehealth locations to estimate the extent to which prisoners housed in BOP-operated institutions used telehealth during the first year of the pandemic and the year prior. To do this, the OIG matched records between the datasets using unique prisoner identifier numbers and proximate date fields.<sup>168</sup>

Using these data, we estimated the number of prisoners in BOP-operated institutions who used telehealth services and the total number of telehealth services they used during the first year of the pandemic and the year prior. We also utilized BOP-provided cost estimates for external telehealth services at BOP institutions with active comprehensive medical service contracts, based on Current Procedural Terminology (CPT) codes selected by the BOP’s comprehensive medical services contractors. In addition, the DOJ OIG conducted analyses of USMS National Managed Care Contract contractor medical claims data to determine the extent to which USMS prisoners used telehealth during the first year of the pandemic and the year prior. To do this, for the USMS, we identified the services that Medicare approved for telehealth during the pandemic, using CPT codes. We then identified claims billed to the USMS’s National Managed Care Contract with these CPT codes that contained at least one of the following: a CPT code modifier (i.e., 95, GT, GQ, or G0); a “place of service code” (i.e., 02, 10) that indicates the service was delivered via telehealth; or a care category of “Virtual Care Services.” We aggregated this filtered list to count telehealth claims and patients across care categories.

Using these data, we determined the number of USMS prisoners who used telehealth services and the total number of claims corresponding to those services in the first year of the pandemic and the year prior. A claim including multiple telehealth services was counted once. We also calculated the total amount paid by the USMS for all telehealth services within each claim using the listed Medicare amount.<sup>169</sup>

To determine the most common telehealth services for the USMS, we grouped each claim into categories based on the Centers for Medicare & Medicaid Services service classification system and CPT codes. We included a claim in multiple categories if it contained services so classified.

**Program Integrity Risks Associated with Telehealth** | We relied on the information described above to inform this section. In addition, we analyzed BOP-provided BEMR consultation request data for specialty care with a selected telehealth location to identify potential risk areas.<sup>170</sup> Specifically, we calculated the number of days between the scheduled “target date” and “send date” fields to identify potential scheduling issues.<sup>171</sup> We also calculated the number of days between the “send date” and “results date” fields to identify potential delays in entering visit results into BEMR.<sup>172</sup>

We also reviewed DOJ OIG hotline complaints and previous OIG work related to BOP health care.

## LIMITATIONS

As discussed in the DOJ OIG's program integrity section of this report, the BOP was unable to provide a comprehensive and unduplicated dataset that would definitively capture the number of telehealth visits with prisoners in facilities it operated. For example, a BOP official stated that a single telehealth visit could be represented by multiple entries in the data they provided. Thus, the DOJ OIG performed analysis to remove potential duplicates by removing entries that occurred within the same 10 day window for a prisoner. Additionally, although we use the term "telehealth visit" in our analysis of BEMR consultation request data to identify potential risk areas, the BOP noted that it had no way to determine whether there were any records representing asynchronous interactions rather than telehealth visits included in the dataset. Further, the telehealth datasets provided by the BOP do not capture telehealth costs and the BOP lacks a national medical claims system capable of centrally tracking total telehealth care costs across its 122 institutions. Telehealth cost estimates provided by the BOP do not capture costs for internal telehealth services provided by BOP providers or services at all BOP institutions.

The DOJ OIG's analysis of USMS telehealth data was limited to USMS National Managed Care Contract contractor claims data for services billed to the USMS. This dataset might not represent the complete universe of telehealth services provided to prisoners in USMS custody, such as for in-house services not billed to the USMS's National Managed Care Contract contractor. We did not assess the BOP and USMS telehealth data for fraud indicators. Any determination of fraud or an overpayment would require additional investigation.

## STANDARDS

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

# Endnotes

- 1 PRAC, [Top Challenges Facing Federal Agencies: COVID-19 Emergency Relief and Response Efforts](#) (as reported by Offices of Inspectors General across government) (Washington, D.C.; June 2020) and PRAC, [Update: Top Challenges in Pandemic Relief and Response](#) (Washington, D.C.; February 3, 2021).
- 2 The Veterans Health Administration provides care directly to eligible individuals through a national system of medical centers and community-based outpatient clinics and under certain circumstances through providers in the community. The DoD uses the Military Health System's health care plan known as TRICARE to provide global direct care to eligible individuals and contracted network providers in the purchased care sector. The DOJ's Federal Bureau of Prisons delivers health care directly to the individuals it serves and under certain circumstances pays for care delivered by other providers in the community. The DOJ's United States Marshals Service may also under certain circumstances pay for care for individuals in its custody delivered by other providers in the community, in addition to paying for care provided inside detention facilities through agreements it maintains with those facilities.
- 3 VHA defines a user as an enrolled veteran who has used VA services within the previous three years. According to the VHA Allocation Resource Center, over 5.6 million veterans were enrolled users of VA health care in March of 2020. [vawww.arc.med.va.gov](http://vawww.arc.med.va.gov). (The website was accessed April 12, 2022. This is a VA internal website.)
- 4 Workers' Compensation did not cover telehealth physical therapy in two of its three programs, and it did not cover telehealth occupational and speech therapy in one of its programs.
- 5 Prior to the pandemic, Medicare did not cover physical, occupational, and speech therapy services, nor assisted living visits, via telehealth. In addition, while the Federal Employees Health Benefits Program did not have a policy that limited the types of services that could be used via telehealth, most insurance carriers reported that prior to the pandemic, they covered fewer services via telehealth. In addition, the Veterans Health Administration policies discussed in this section of the report describe the policies for telehealth services provided directly by VA-employed providers. The Veterans Health Administration's Community Care program follows Medicare telehealth policies.
- 6 The DOJ prisoner health care services do not have policies about audio-only telehealth; however, the Federal Bureau of Prisons reported using the telephone to conduct telehealth.
- 7 Prior to the pandemic, beneficiaries were allowed to use virtual care services, as well as telehealth services to address substance use disorder or end-stage renal disease, from their homes and in urban areas. In addition, beginning January 1, 2020, Medicare Advantage had greater flexibility to provide telehealth services to beneficiaries. For example, plans could provide services to beneficiaries in their homes and regardless of beneficiaries' geographic location.
- 8 The American Rescue Plan Act of 2021 allowed VA to reimburse veterans or waive copayments or other cost-sharing for care provided from April 6, 2020, through September 30, 2021.
- 9 Federal prisoners housed in state and local facilities in the United States Marshals Service's custody can be assessed reasonable fees for certain health care services.
- 10 Providers could choose to reduce or waive beneficiary copayments for telehealth services during the pandemic, without being subject to administrative action. See HHS OIG, *OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak*, March 17, 2020.
- 11 Prior to the pandemic, Medicare paid equivalent amounts for telehealth and in-person services under certain circumstances.
- 12 The totals represent the aggregated number of individuals who used telehealth in each program. Individuals who used telehealth in more than one program may be counted multiple times. Also note that data from the Federal Employees Health Benefits Program includes the data from the largest insurer, which represents approximately 68 percent of individuals enrolled in all plans. In addition, data for the DOJ prisoner health care services, which include data from the Federal Bureau of Prisons and the United States Marshals Service, are incomplete because of data limitations.

- 13 The percentage for the Veterans Health Administration is based on those veterans who are enrolled active users who received telehealth services directly from VA providers.
- 14 Behavioral health services accounted for 31 percent of telehealth services in Workers' Compensation and 33 percent of telehealth services in the Federal Employees Health Benefits Program.
- 15 Virtual care services are a type of telehealth service that is always provided remotely, unlike other types of services that can also be provided in-person. Examples of virtual care services include telephone calls with a provider or interactions via an online patient portal, and remote monitoring, such as weight and blood pressure checks.
- 16 According to billing guidelines, the 45-minute code is used for 38 to 52 minutes of therapy, while the 60-minute code is used for 53 minutes and beyond.
- 17 See HHS OIG, *Principal Deputy Inspector General Grimm on Telehealth*, February 26, 2021.
- 18 DOJ, *Laboratory Owner Sentenced to 82 Months in Prison for COVID-19 Kickback Scheme*, November 9, 2021.
- 19 DOJ, *National Health Care Fraud Enforcement Action Results in Charges Involving over \$1.4 billion in Alleged Losses*, September 17, 2021. See also DOJ, *Laboratory Owner Sentenced to 82 Months in Prison for COVID-19 Kickback Scheme*, November 9, 2021.
- 20 "Incident to" billing allows clinical staff who are directly supervised by a practitioner to bill for services under the supervising practitioner's identification number.
- 21 This report focuses on the use of telehealth between a patient and a provider; it does not include provider-to-provider interactions. This report does not focus on issues related to privacy and technology.
- 22 This review includes the telehealth services approved for payment by Medicare as of February 28, 2021. It does not include telehealth services billed by institutions to Medicare Part A.
- 23 For the purposes of this report, we refer to the services that can be delivered either via telehealth or in-person—as well as services that are always provided remotely—as telehealth services. CMS does not include services that are always provided remotely in its formal definition of telehealth services.
- 24 HHS and CMS were able to temporarily expand access to telehealth because of their waiver authority under section 1135 of the Social Security Act, subsequent legislation, and the Secretary's declaration of a public health emergency due to COVID-19. The Public Health Emergency was announced on January 31, 2020. See HHS, *Determination that a Public Health Emergency Exists*, January 31, 2020, accessed at <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx> on April 8, 2022. See also, Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020, accessed <https://www.congress.gov/bill/116th-congress/house-bill/6074/text/rds> on November 23, 2021. See also, Families First Coronavirus Response Act, accessed at <https://www.congress.gov/bill/116th-congress/house-bill/6201/text> on April 15, 2022. See also, The Coronavirus Aid, Relief, and Economic Security Act (CARES Act), accessed at <https://www.congress.gov/bill/116th-congress/house-bill/748/text> on November 23, 2021. See also HHS Office of Civil Rights, *Bulletin: HIPAA Privacy and Novel Coronavirus*, February 2020.
- 25 These policies apply to both Medicare fee-for-service and Medicare Advantage plans; however, Medicare Advantage plans had the flexibility to offer extra telehealth benefits both prior to and during the pandemic.
- 26 Prior to the pandemic, beneficiaries could receive certain services, such as virtual check-ins, through audio-only.
- 27 Unlike in Medicare fee-for-service, beneficiaries enrolled in certain Medicare Advantage plans were allowed beginning January 1, 2020, to receive telehealth services both from home and in urban areas.
- 28 Providers could choose to reduce or waive beneficiary copayments for telehealth services during the pandemic, without being subject to administrative action. See HHS OIG, *OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak*, March 17, 2020.
- 29 For more detailed information about the use of telehealth during the pandemic, see HHS OIG, *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*, OEI-02-20-00520, March 2022.
- 30 Payment information is not available for patients enrolled in Medicare Advantage.



- 31 HHS OIG, *Most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship*, OEI-02-20-00521, October 2021. This study looked at telehealth services used by Medicare beneficiaries from March 2020 through December 2020.
- 32 HHS OIG, *Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic*, OEI-02-20-00522, September 2022.
- 33 CMS cannot distinguish between audio-only and audio-video for these 86 services. In addition, Medicare Advantage plans can offer additional telehealth services that may include audio-only services that cannot be identified in the data. Further, CMS recently required providers to use a modifier to identify audio-only services for the treatment of certain mental health conditions. See 86 FR 64996 (November 19, 2021).
- 34 It does not include program integrity risks related to cybersecurity or patient privacy.
- 35 For more detailed information about the measures and the providers we identified, see HHS OIG, *Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks*, OEI-02-20-00720, September 2022.
- 36 These measures do not include telemarketing schemes that do not involve billing for telehealth services. Those telemarketing schemes—often referred to as telefraud—generally involve a phone call or other remote interaction with a beneficiary to order or prescribe medically unnecessary testing, equipment, or prescriptions. See HHS OIG, *Principal Deputy Inspector General Grimm on Telehealth*, February 26, 2021.
- 37 See HHS OIG, *Principal Deputy Inspector General Grimm on Telehealth*, February 26, 2021.
- 38 DOJ, *Laboratory Owner Sentenced to 82 Months in Prison for COVID-19 Kickback Scheme*, November 9, 2021.
- 39 DOJ, *National Health Care Fraud Enforcement Action Results in Charges Involving over \$1.4 billion in Alleged Losses*, September 17, 2021.
- 40 HHS OIG, *Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic*, OEI-02-20-00522, September 2022.
- 41 For additional information, also see Agency for Healthcare Research and Quality, *The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic*, May 2020.
- 42 C. Jones, C. Shoff, K. Hodges, C. Blanco, J. Losby, S. Ling, and W. Compton, “Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID-19 Pandemic.” *JAMA Psychiatry*, p. E9.
- 43 Medicaid is a health care program jointly administered by CMS and States that serves certain populations with low incomes. Some Medicare beneficiaries are also enrolled in Medicaid. HHS OIG, *Opportunities Exist To Strengthen Evaluation and Oversight of Telehealth for Behavioral Health in Medicaid*, OEI-02-19-00401, September 2021.
- 44 CMS could distinguish audio-only for six telehealth services during our review period. Effective January 1, 2022, CMS began requiring providers to use a modifier to identify audio-only services for the treatment of mental health conditions. See 86 FR 64996 (November 19, 2021).
- 45 This lack of transparency for “incident to” billing also affects oversight of services provided in-person. See HHS OIG, *Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks*, OEI-02-20-00720, September 2022.
- 46 Telehealth companies are companies that employ practitioners to provide on-demand telehealth services to beneficiaries. Unlike other providers, telehealth companies do not offer in-person services. See HHS OIG, *Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks*, OEI-02-20-00720, September 2022.
- 47 HHS OIG, *Many Medicare Beneficiaries Are Not Receiving Medication to Treat Their Opioid Use Disorder*, OEI-02-20-00390, December 2021.
- 48 Additionally, CMS is part of the Healthcare Fraud Prevention Partnership. For more information on CMS’s Fraud Prevention System and Healthcare Fraud Prevention Partnership, see <https://www.cms.gov/About-CMS/Components/CPI/CPI-Investing-In-Data-and-Analytics>.
- 49 For more information on CMS’s Fraud Prevention System and Healthcare Fraud Prevention Partnership, see <https://www.cms.gov/About-CMS/Components/CPI/CPI-Investing-In-Data-and-Analytics>.



- 50 Noridian, 01-058 *Traditional Telehealth Notification of Medical Review*, February 2022. See also, Noridian, 01-055 *Audio Only Telehealth Services During the PHE Notification of Medical Review*, February 2022.
- 51 See HHS OIG, *Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks*, OEI-02-20-00720, September 2022. Also see HHS OIG, *Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic*, OEI-02-20-00522, September 2022, and HHS OIG, *Many Medicare Beneficiaries Are Not Receiving Medication to Treat Their Opioid Use Disorder*, OEI-02-20-00390, December 2021.
- 52 TRICARE Policy Manual 6010.60M, April 1, 2015.
- 53 Medicare Part A helps pay for inpatient care in a hospital or for a limited time in a skilled nursing facility. Medicare Part B helps pay for services from doctors and other health care providers, outpatient care, home health care, durable medical equipment, and some preventive services.
- 54 TRICARE Reimbursement Manual 6010.61M, April 1, 2015.
- 55 Title 32 Code of Federal Regulations (CFR) section 199.6.
- 56 The two contractors are responsible for managing the authorized private sector provider networks in the eastern and western continental United States. For the purpose of this report, we will use the term “private sector beneficiaries” to refer to beneficiaries only enrolled in TRICARE East and West within the continental United States. See Appendix B for the DoD OIG’s methodology.
- 57 85 Fed. Reg. 27,921 (2020).
- 58 As of April 2022, these temporary changes are still in effect.
- 59 Report No. DODIG-2022-047, “Audit of TRICARE Telehealth Payments,” February 3, 2022.
- 60 The “originating site” is the location of the patient receiving telehealth services and must be an authorized health care facility.
- 61 The “distant site” is the location of the health care provider providing telehealth services.
- 62 TRICARE Operations Manual 6010.59M, April 1, 2015.
- 63 TRICARE Policy Manual 6010.60M, April 1, 2015.
- 64 DHA, “Program Integrity Division Operational Report Calendar Year 2020,” June 10, 2021.
- 65 The managed care support contractors designed prepayment edits to prevent payment for non-covered and incorrectly coded services and to select targeted claims for review prior to payment.
- 66 Report No. DODIG-2022-047, “Audit of TRICARE Telehealth Payments,” February 3, 2022.
- 67 Experience-rated fee-for-service carrier – A carrier whose future medical costs are based on its past experience, which considers a carrier’s actual paid claims; administrative expenses (including capitated administrative expenses); retentions; and estimated claims incurred but not reported that are adjusted for benefit modifications, utilization trends, and economic trends.
- 68 Experience-rated health maintenance organization carrier – A carrier whose future medical costs are based on its past experience, which considers its medical history and claims experience in determining premiums.
- 69 Community-rated health maintenance organization carrier – Community-rated organizations allocate risks evenly across a community, based on the medical statistics of a community. This means that a premium is derived for the entire community without regard to age, gender, or health and wellness.
- 70 Carrier Letter – Instructions or guidance from OPM to the FEHBP Carrier organizations to provide information, instruction, and or guidance on various subjects published throughout any given year.
- 71 Health savings accounts – A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses such as deductibles, copayments, coinsurance, and some other expenses.
- 72 Qualified high deductible health plan – A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible).

- 73 Access portals – The carrier, patient, or provider portals allowing authorized users to access information about care and treatment, enabling patients to access their electronic medical records (EMRs), and facilitating patient-provider communication by connecting with a doctor through a convenient electronic environment.
- 74 Continuity of care – Continuity of care is an approach to ensure that the patient-centered care team is cooperatively involved in ongoing health care management toward a shared goal of high-quality medical care. Continuity of care is concerned with the quality of care over time.
- 75 It does not include program integrity risks related to cybersecurity or patient privacy.
- 76 These measures do not include telemarketing schemes that do not involve billing for telehealth services. Those telemarketing schemes—often referred to as telefraud—generally involve a phone call or other remote interaction with a member to order or prescribe medically unnecessary testing, equipment, or prescriptions.
- 77 Source: Analysis of the OPM OIG Claims Data Warehouse; data analysis was based on claims data from one carrier, covering approximately 68 percent of enrolled members.
- 78 See FEHBP Carrier Letters 2017-01, 2019-01, 2019-05, 2020-02, 2020-08, 2021-03, and 2021-05.
- 79 Program integrity safeguards – Controls put in place to combat FEHBP provider fraud, waste, and abuse.
- 80 Coordination of benefits – To determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one health and/or prescription plan.
- 81 Impossible days – A provider sees a large volume of patients in a day (e.g., an individual provider has billed for more than 24 hours of time on a given date).
- 82 Preferred Provider – For the purposes of this analysis, a preferred provider is a provider who offers both telehealth and in-person services, typically working in a brick-and-mortar setting, as opposed to a provider who exclusively offers telehealth services through a telehealth company.
- 83 <https://oig.opm.gov/contact/hotline>
- 84 <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
- 85 <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2016/2016-03.pdf>
- 86 VA defines a user as an enrolled veteran who has used VA services within the previous three years. According to the VHA Allocation Resource Center, over 5.6 million veterans were enrolled users of VA health care in March of 2020. [vawww.arc.med.va.gov](http://vawww.arc.med.va.gov). (The website was accessed April 12, 2022. This is an internal website.)
- 87 VA medical benefits package includes inpatient and outpatient care, primary and specialty care, preventive care, diagnostic and treatment services, long term care, mental health care, pharmacy benefits, and other services. [https://www.va.gov/healthbenefits/resources/publications/hbco/hbco\\_medical\\_benefits\\_package.asp](https://www.va.gov/healthbenefits/resources/publications/hbco/hbco_medical_benefits_package.asp) (The website was accessed April 29, 2022.)
- 88 Congressional Research Service, “Department of Veterans Affairs (VA): A Primer on Telehealth”, July 26, 2019. <https://crsreports.congress.gov/product/pdf/R/R45834> (The website was accessed August 25, 2021.)  
Darkins, Adam. “The Growth of Telehealth Services in the Veterans Health Administration Between 1994 and 2014: A Study in the Diffusion of Innovation,” *Telemedicine and e-Health*, September 3, 2014. <https://doi.org/10.1089/tmj.2014.0143> (The website was accessed April 20, 2022.)
- 89 VA Directive 1914, *Telehealth Clinical Resource Sharing Between VA Facilities and Telehealth from Approved Alternative Worksites*, April 27, 2020. VA defines telehealth as the “use of electronic information or telecommunications technologies to support clinical health care, patient and professional health-related education, public health, or health administration at a distance.”
- 90 Federal Register, “Authority of Health Care Providers to Practice Telehealth,” Vol 83, No. 92, May 11, 2018. Congressional Research Service, Department of Veterans Affairs (VA): A Primer on Telehealth, July 26, 2019. <https://crsreports.congress.gov/product/pdf/R/R45834>. (The website was accessed August 25, 2021.)
- 91 Congressional Budget Office, *The Veterans Community Care Program: Background and Early Effects*, October 2021.

- 92 VA provides care to veterans through non-VA community care providers under certain conditions, such as when care is not available at a VA facility. <https://www.va.gov/communitycare/>. (The website was accessed April 20, 2022.)
- 93 Ancillary health services aid in the diagnosis and treatment of medical conditions. VA ancillary services include, but are not limited to, pharmacy, x-ray and imaging services, physical and occupational therapy, speech and language pathology, and audiology. [https://www.va.gov/healthbenefits/access/ancillary\\_services.asp](https://www.va.gov/healthbenefits/access/ancillary_services.asp) (The website was accessed April 22, 2022.)
- 94 We extended the period considered as the pandemic through December 2021 based on the availability of claims data at the time of this review. These numbers are subject to increase as TPAs process and adjudicate additional VA community care telehealth claims.
- 95 VHA Directive 1914, *Telehealth Clinical Resource Sharing Between VA Facilities and Telehealth from Approved Alternative Worksites*, “This directive defines national standards and responsibilities for sharing health care professional services across VHA facilities through telehealth.” The purpose of this directive was to “reduce administrative requirements for telehealth program activation” while “maintaining quality processes that ensure oversight of health care professional practice.” April 27, 2020. VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012, and VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021, detail requirements for credentialing and privileging of health care providers within VHA.
- 96 VA’s Corporate Data Warehouse provides “high-performance business intelligence infrastructure through standardization, consolidation, and streamlining of clinical data systems.” [https://www.hsrp.research.va.gov/for\\_researchers/cdw.cfm](https://www.hsrp.research.va.gov/for_researchers/cdw.cfm) (The website was accessed July 7, 2022.)
- 97 According to CMS, telehealth is defined as routine office visits provided via synchronous, real-time audio and video communication. CMS defines e-visits as asynchronous (not real-time) communication with a patient through a patient portal or other online method.
- 98 CMS, COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, March 30, 2020.
- 99 Where numbers are rounded for reporting purposes, we extended the period considered as the pandemic through December 2021 based on the availability of data at the time of the review and because the pandemic is ongoing. These numbers are subject to increase as TPAs process and adjudicate additional VA community care telehealth claims.
- 100 Because of rounding, these totals are not the sum of the data points detailed in Exhibit 5.
- 101 Berenson-Eggers Type of Service codes are clinical categories that can be used to analyze how Medicare expenditures grow in a specific clinical area. Each unique code is assigned to each Healthcare Common Procedure Coding System code. The codes include evaluation and management, procedures, and imaging.
- 102 VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.
- 103 Medicare Payment Advisory Commission, “Report To The Congress Medicare Payment Policy,” March 2021.
- 104 Due to claims with more than one risk, the totals for each payment risk area do not sum to the total community care telehealth payments. For example, a claim may have included an ineligible service on a high-usage day. Appendix D provides additional details on the review’s methodology.
- 105 Appendix D provides additional details on the review’s methodology for this objective.
- 106 Our calculation of 23,400 providers includes all providers with at least one high-intensity claim.
- 107 The cost avoidance and recovery (and recoupment) reports include TPA cost avoidance and recovery data, such as the analysis of claims identified as being overpaid for the period under review.
- 108 Assistant under secretary for health for operations (10N) memo, “Expanding Access to Telehealth for Veterans through the Digital Divide Consult,” August 12, 2020. This summary of the Digital Divide program refers to work included in VA OIG, *Digital Divide Consults and Devices for VA Video Connect Appointments*, Report No. 21 02668 182, August 4, 2022.
- 109 A digital divide consult can also be used to help veterans benefit from additional federal subsidies, in addition to the video-capable device. The consult helps identify a need, and grant government subsidies, for reduced-cost internet service for patients.

- 110 VA's Office of Connected Care, "Digital Divide Consult Process SOP [Standard Operating Procedure]," November 2020, retitled "Digital Divide Standard Operating Procedure" and revised May, July, and December 2021 and February 2022.
- 111 Gujral, Kritee, PhD; et al. "Mental Health Service Use, Suicide Behavior, and Emergency Department Visits Among Rural US Veterans Who Received Video-Enabled Tablets During the COVID-19 Pandemic." JAMA Network Open. JAMA Network, April 6, 2022. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2790743>.
- 112 For reasons discussed later, the Longshore program will not be covered in this report.
- 113 For the Longshore program, the employers or the insurance carriers authorize medical treatment.
- 114 5 U.S. Code § 8103(a)
- 115 Coal workers' pneumoconiosis, commonly referred to as black lung disease, is a lung disease caused by inhalation of coal dust.
- 116 Part B of the Energy program went into effect on July 31, 2001, and Part E of the Program went into effect on October 28, 2004.
- 117 For a small number of cases where both the responsible employer and its insurance carrier are insolvent or are out of business, medical benefits are paid out of the Longshore and Harbor Workers' Compensation Act Special Fund (Longshore Special Fund). In FY 2021, the Longshore Special Fund paid medical benefits for 34 cases. According to the Longshore program, it has not paid for any telehealth services out of the Longshore Special Fund.
- 118 In March 2021, the FECA program updated its telehealth policy to allow seven additional medical procedures and removed three medical procedures that were previously allowed.
- 119 The Black Lung program requires the claimant's address to be the delivery location for the delivery of medical care via telehealth.
- 120 OWCP utilizes the following modifiers for telehealth services: GT (via interactive audio and video telecommunications systems), GQ (via an asynchronous telecommunications system), and 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system).
- 121 In addition to the bill for services, the Black Lung program requires the physician or health care provider to provide the following information: a note stating the method of telemedicine used; any vitals or medical evidence collected; and an outline of the medical need and benefit derived from the service, as it relates to the claimant's accepted condition.
- 122 E-visits allow patients to talk to their doctor using an online patient portal without going to the doctor's office.
- 123 Although telehealth was not specifically authorized prior to the pandemic, the Energy program paid for the services if appropriate for the medical condition.
- 124 Although telehealth was not allowed prior to the pandemic, the Black Lung program retroactively paid \$47 for one telehealth service provided to one claimant on February 20, 2020, because the bill was received after the President of the United States declared COVID-19 a National Emergency on March 13, 2020.
- 125 OWCP covered the following three procedure codes related to telephone evaluation and management services by a physician or other qualified health care professional: 99441 (a 5- to 10-minute discussion), 99442 (an 11- to 20-minute discussion), 99443 (a 21- to 30-minute discussion).
- 126 Carpal Tunnel Syndrome is a condition that causes pain, numbness, or tingling in both hands and fingers at the same time.
- 127 According to billing guidelines, the 45-minute code is used for 38 to 52 minutes of therapy, while the 60-minute code is used for 53 minutes and beyond.
- 128 The Federal Bureau of Prisons (BOP) and the U.S. Marshals Service (USMS) are the DOJ components responsible for the custody and care of federal prisoners. The BOP is responsible for confining federal prisoners in controlled environments that are safe and secure and must also ensure that prisoners are housed in humane facilities and receive adequate health care. The USMS is responsible for providing safe, secure, and humane custody, housing, medical care, and transportation to prisoners awaiting trial or sentencing decisions.

- 129 BOP population totals account for prisoners housed at BOP-operated institutions only. The total number of prisoners housed at BOP-operated institutions, contract prisons, and Residential Re-entry Centers (RRCs) was approximately 175,000 at the end of February 2020 and 152,000 at the end of February 2021. USMS population totals include all USMS prisoners. The total number of USMS prisoners housed in non-BOP institution settings was approximately 55,000 at the end of February 2020 and February 2021.
- 130 The BOP does not capture the costs of these internal encounters independently from the salary expenses of its personnel in these roles.
- 131 According to the BOP, telehealth telephone services are not a line item in comprehensive medical services contracts awarded at BOP institutions. The BOP may complete contract enhancements for telehealth services at BOP institutions.
- 132 Pursuant to a memorandum of understanding between the BOP and the USMS, the BOP is responsible for all costs, including medical costs, associated with housing USMS prisoners in BOP facilities.
- 133 Prisoners housed in state and local facilities may also be assessed reasonable fees for medical services other than those addressing preventive health care services, emergency services, prenatal care, diagnosis or treatment of chronic infectious diseases, mental health care, or substance abuse treatment. See 18 U.S.C. § 4013(d).
- 134 As of September 2022, the BOP reported that it was developing a draft policy specific to telehealth.
- 135 To estimate the number of telehealth visits at BOP institutions, the OIG matched records between two BOP-provided datasets. The telehealth visit figures presented in this paragraph are estimates due to BOP data limitations.
- 136 The BOP retained one of the mobile telehealth stations for use at BOP headquarters.
- 137 These waivers also no longer required institutions to maintain institution-specific privileges and practice agreements. The BOP's February 2022 waiver stipulated that external telehealth providers follow contract requirements, that the comprehensive contract holder verify external telehealth provider credentials, and that current credentials for external telehealth providers be available for review by BOP institutions.
- 138 See 18 U.S.C. § 4006(b)(1). Note: the pricing stipulations in this statute do not include the BOP.
- 139 According to the BOP, the vast majority of health care services are provided onsite at institutions.
- 140 Although the DOJ OIG is using the snapshot prisoner populations as of the end of February 2020 and February 2021 to compare relative proportions of prisoners who used telehealth services, the total number of prisoners who were in BOP-operated institutions would likely vary from the 146,000 and 124,000 figures because of prisoner flows in and out of the system during the years in question. The prisoner population in BOP-operated institutions decreased during the first year of the pandemic.
- 141 The USMS National Managed Care Contract contractor claims data did not include data on telehealth services provided to USMS prisoners housed in BOP-operated institutions, as the BOP is responsible for the costs of medical care provided to those prisoners.
- 142 Although the DOJ OIG is using the snapshot prisoner populations as of the end of February 2020 and February 2021 to compare relative proportions of prisoners who used telehealth services, the total number of prisoners in USMS custody during those years would likely vary from the 65,000 and 64,000 figures because of prisoner flows in and out of the system during the years in question.
- 143 The BOP provided these estimates based on CPT codes selected by the BOP's comprehensive medical services contractors to represent external telehealth care, at institutions with an active comprehensive medical services contract. However, these estimates likely under-represent the total costs of external telehealth services because only 80 percent of BOP institutions, approximately, had an active comprehensive medical services contract as of April 2022. The BOP's selection of CPT codes to estimate the cost of telehealth services differs from the CPT codes used to estimate the USMS's telehealth costs.
- 144 As noted above, in certain situations prisoners in BOP custody may also receive care through internal telehealth visits with BOP-employed providers via remote connection from the institution housing the prisoner to a BOP clinical staff member working at another location.
- 145 Due to BOP data limitations, this analysis is specific to categories of telehealth care for specialty care only, as the BOP provided more descriptive categories for specialty care delivered via telehealth.



- 146 Federal Medical Centers provide care to prisoners in need of more advanced medical or mental health care, compared to prisoners housed in other BOP institutions. Six of the BOP's 122 institutions are Federal Medical Centers.
- 147 DOJ OIG, *Audit of the Federal Bureau of Prisons' Contract Awarded to Correct Care Solutions, LLC for the Federal Correctional Complex in Coleman, Florida*, Audit Report 19-37. The OIG closed all recommendations from this report in August 2021.
- 148 DOJ OIG, *Notification of Concerns Regarding Potential Overpayment by the Federal Bureau of Prisons for Inmate Health Care Services*, Investigations Management Advisory Memorandum 22-035. The scope of the Management Advisory Memorandum included one Comprehensive Medical Services contractor. In June 2022, the OIG closed its recommendation to the BOP to establish and implement a plan to ensure that all current and future Comprehensive Medical Services contractors use CPT/Healthcare Common Procedure Coding System codes selected by their contracted service providers when submitting requests for reimbursement to the BOP rather than choosing such codes themselves.
- 149 DOJ OIG, *Procedural Reform Recommendation for the Federal Bureau of Prisons*, Investigations Procedural Reform Recommendation, 2016-008873.
- 150 According to the BOP, as of May 2022, the BOP has included the adjudication language in all new comprehensive medical services requirements (new solicitations). The BOP further noted that it will complete bill adjudication modifications to existing contracts.
- 151 DOJ OIG, *Audit of the Federal Bureau of Prisons Comprehensive Medical Services Contracts Awarded to the University of Massachusetts Medical School*, Audit Report 22-052.
- 152 This review includes the telehealth services approved for payment by Medicare as of February 28, 2021. It does not include telehealth services billed by institutions.
- 153 For more information on this analysis, see HHS OIG, *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*, OEI-02-20-00520, March 2022.
- 154 The codes used in the analysis include the list available on the CMS website as of February 28, 2021, which can be found at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>. We also included virtual care services as a type of telehealth service. These services are also referred to as Communication Technology-Based Services. They are always provided remotely, and include virtual check-ins, e-visits, remote monitoring, and telephone calls with a provider to discuss a beneficiary's medical condition. See 85 FR 19230 (April 6, 2020) and 85 FR 84472 (December 20, 2020).
- 155 All virtual care service codes were considered as being provided via telehealth, as these services can only be provided remotely.
- 156 For this analysis, we considered providers with the same billing identification number—such as those in the same medical practice—to be the same. For more information about this analysis, see HHS OIG, *Most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship*, OEI-02-20-00521, October 2021.
- 157 For more information about these measures, see HHS OIG, *Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks*, OEI-02-20-00720, September 2022.
- 158 TRICARE Operations Manual 6010.59M, April 1, 2015. TRICARE Policy Manual 6010.60M, April 1, 2015. The DHA telehealth encounter summary report is a summary of the encounter data from the Military Health System Data Repository, which included TRICARE beneficiary telehealth encounters and expenditures for telehealth claims.
- 159 Report No. DODOIG-2022-047, "Audit of TRICARE Telehealth Payments," February 3, 2022.
- 160 This review includes the telehealth services incurred as of December 31, 2021.
- 161 All virtual care service codes were considered as being provided via telehealth as they can only be provided remotely.
- 162 Categories based on the Restructured BETOS Classification System as of August 20, 2021, which can be found at <https://data.cms.gov/provider-summary-by-type-of-service/provider-service-classifications/restructured-betos-classification-system>.

- 163 The primary stop code is a three-digit number which designates the clinical group responsible for the care provided to a patient. The secondary stop code serves as a modifier to further describe the clinical work, such as the telehealth modality of care.
- 164 Telehealth claims were identified if it had a Place-of-Service code of 02, or a modifier of 95, G0, GQ, or GT. Telehealth CPT codes - claim lines billed with the following telehealth CPT codes - G0071, G2012, G2010, 99421, 99422, 99423, G2025, G2061, G2062, G2063, 98966, 98967, 98968, 98969, or Q3014.
- 165 VA OIG, *Digital Divide Consults and Devices for VA Video Connect Appointments*, Report No. 21 02668 182, August 4, 2022.
- 166 We excluded 4,377 telehealth services paid by OWCP with the following procedure codes: 99080 (Special Reports), 99367 (Medical Team Conference), and S9999 (Sales Tax).
- 167 For more information, please see: *Alert Memorandum: The Office of Workers' Compensation Programs' Workers' Compensation Medical Bill Process System Data Were of Undetermined Reliability*, DOL OIG Report No. 23-22-002-04-001.
- 168 As noted in DOJ OIG's program integrity report section, the BOP advised that it could not definitively tell whether records from the two datasets represented patient-to-provider telehealth visits. To estimate the number of telehealth services and prisoners in BOP-operated institutions who used telehealth, the OIG counted matches between the datasets that appeared in certain categories.
- 169 As noted in the DOJ OIG's program integrity report section, these figures represent only the costs of telehealth services billed to the USMS National Managed Care Contract and might not represent the total costs of all telehealth services provided to prisoners in USMS custody.
- 170 We analyzed all records in this dataset for this analysis.
- 171 The scheduled target date is the date by which BOP personnel would have preferred for a visit to occur, and the send date is the date a telehealth visit occurred.
- 172 The results date is the date that visit results were entered into BEMR.



# Acknowledgments

This report was prepared under the guidance of the PRAC Health Care Subgroup, chaired by HHS Inspector General, Christi A. Grimm, and led by HHS OIG in collaboration with DoD OIG, OPM OIG, VA OIG, DOL OIG, DOJ OIG, and PRAC professional staff. Special acknowledgments to the following staff who collaborated on this report:

**HHS OIG:** Jodi Nudelman, Miriam Anderson, John Gordon, Vincent Greiber, Alexis Mills, Erin Bliss, Megan Tinker, and Andrew VanLandingham.

**DoD OIG:** Maurice Foster, Kaleab Tesfaye, Matthew Worner, Emil Kabban, Towanda Meredith, Laurel Gosmen, and Kevin Acosta.

**OPM OIG:** Stephanie Oliver, Jasmine Taylor, Michael Weaver, and Dawn Schauer.

**VA OIG:** Jennifer Baptiste, MD; Irene J. Barnett, Ph.D.; Kim Cragg; Benjamin Howe; Julie Kroviak, MD; Patrice Marcarelli, MD; Daniel Morris; Andrea Sandoval; Leigh Ann Searight; and David Vibe, MBA.

**DOL OIG:** Brittany Arias, Dennis Asante, Nicholas Christopher, Richard Fitzgerald, Y.C. Lee, Jon Ling, and Stephen Sovich.

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