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Finding Our Way Out of the Pandemic Haze: What Telehealth Tools Are Medicare Providers Allowed to Keep, and Which Must They Leave Behind?

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During the COVID-19 pandemic, Medicare coverage expanded to include a vast arsenal of tools that help patients access medical services while keeping patients and practitioners safe. Many of these tools involve telehealth services and were made possible by the COVID-19 emergency blanket waivers, which went into effect when the U.S. Department of Health & Human Services ("HHS") declared a Public Health Emergency (the "PHE"). Some of these tools:

- Permitted providers to furnish distant site telehealth services;
- Expanded the use of audio-only telehealth to behavioral health counseling services; and
- Facilitated the conducting of telehealth appointments by practitioners from their homes while billing from their currently enrolled locations.

As a result of these efforts, the use of telehealth and telemedicine exploded in 2020 according to an HHS Study. This growth was no surprise given the unparalleled advantages of conducting a variety of medical appointments from remote locations in a time where limiting one's exposure to the COVID-19 virus was paramount. Despite the current trend towards relaxing previously stringent regulations on exposure and contact, many providers and patients prefer telehealth services as the primary method of treatment.

This post provides an overview of recent developments in the adoption of telehealth tools by providers, the status of Medicare coverage for telemedicine services, the regulatory vision for the ascent out of the PHE, and fraud, waste and abuse considerations as we begin to make our way out of the pandemic haze.

When does the PHE current expire?

The blanket waivers that expand Medicare coverage of certain telehealth technology are in effect so long as the Secretary of HHS has declared a COVID-19 public health emergency. The first PHE was declared in 2020 and has been renewed every 90 days since then. The latest HHS extension for the PHE is effective through January 11, 2023.

The PHE status is very likely to continue to be extended beyond next January given a possible surge in COVID-19 infections in the United States this winter, according to two Biden administration officials. Moreover, in a letter to the state governors, HHS has indicated that they will provide at least a 60-day notice before the current PHE ends (i.e., on or before November 11, 2022) in the event that it does not intend to issue an extension. To date, the agency has not provided that notice.

Updates on the status of HHS declarations of public health emergencies are available via the federal government's PHE tracker.

Adoption of Telehealth Tools by Providers

Looking towards the future, many providers anticipate keeping some COVID era telehealth tools in their arsenal after the PHE has ended. According to a recent study by the American Medical Association, tele-visit tools ranked highest in provider enthusiasm, provider adoption and improved patient outcomes in comparison to other digital health tools. The vast majority of physicians who have not yet incorporated these tools are seeking to utilize them in the next three years.

The Regulatory Vision For the Ascent Out of the PHE

CMS has outlined their strategy for assessing which blanket waivers should stay in effect after the last PHE extension expires. The strategy consists of three concurrent phases:

- Phase1: Evaluating blanket waivers based on the current stage of the PHE as compared to when the waivers were first issued.

- Phase 2: Keeping tools in place which would be the most helpful in future PHEs, to ensure a rapid response both locally and nationally.

- Phase 3: Continuing coverage of flexibilities that are aimed at producing high-quality care and health equity. CMS is working with the healthcare industry to holistically prepare our health care system for future PHEs.

Medicare Coverage in Advance of Expiration of the PHE

Effective as of January 1, 2022, CMS finalized a rule as part of the FY22 Medicare Physician Fee Schedule that expanded Medicare coverage of telehealth for behavioral health services to facilitate greater access and equitable services for those who may not have access to mental health services providers.

Most recently, on November 1, 2022, CMS issued the Medicare Physician Fee Schedule (MPFS) 2023 Final Rule (the "2023 Final Rule"), which includes policy revisions and guidance regarding

Medicare telehealth services. For example, several services that are temporarily available as telehealth services for the PHE were made available through CY 2023 in order to allow additional time for the collection of data that may support their inclusion as permanent additions to the Medicare Telehealth Services List. CMS also confirmed its intention to implement provisions such as allowing telehealth services to be furnished in any geographic area and in any originating site setting via program instruction or other sub-regulatory guidance to ensure a smooth transition after the end of the PHE.

Proposed Legislation to Continue and Expand Medicare Coverage of Telehealth Services

The American Hospital Association is one of many groups that urged Congress to expand and make permanent the regulatory flexibilities granted to Medicare telehealth services during the PHE. This strong support in favor of extending and expanding Medicare coverage of telehealth flexibilities was repeated again in a letter sent by 375 organizations to Senate leaders on September 13, 2022. The letter indicates several specific telehealth tools, such as lifting in-person requirements for tele-mental health and waiver of location limitations, that have been among the most integral to bringing needed care to patients in the age of technology.

To that end, there are currently several bills in the Senate and House, which would codify much of the progress in telehealth service coverage that providers and industry organizations are seeking. In the Senate, the Telehealth Extension and Evaluation Act was introduced in February of 2022. The bill proposes an extension of and modification to Medicare coverage of four specific telehealth tools. This expansion would continue for two years after the PHE expires. Representatives in the House introduced the Ensuring Telehealth Expansion Act of 2021 in January of 2021. This bill would make Medicare coverage of telehealth flexibilities permanent outside of the PHE.

Recently, the Advancing Telehealth Beyond COVID-19 Act of 2022 was passed by the House and is now being reviewed by the Senate. This bill modifies the extension of certain Medicare telehealth flexibilities and provides that some of them continue to apply until December 31, 2024, in the event that the PHE ends before that date. For example, the bill allows beneficiaries to continue to receive telehealth services at any site, regardless of type or location (e.g., the beneficiary's home), occupational therapists, physical therapists, speech-language pathologists, and audiologists to continue to furnish telehealth services, and federally qualified health centers and rural health clinics to continue to serve as the distant site (i.e., the location of the health care practitioner) for telehealth services.

Fraud, Waste and Abuse of Telehealth Services

The COVID-19 emergency blanket waivers have been a useful tool for healthcare providers, but the expansion of Medicare coverage of telehealth during the PHE has also presented the opportunity for fraud, waste and abuse. In a recent report (the "Report") the HHS Office of the Inspector General ("OIG"), identified 1,714 out of 742,000 providers as "high risk" for fraud, waste, or abuse with respect to their billing practices for telehealth services. OIG identified several billing practices that may be indicative of providers it considers to be "high risk" of engaging in Medicare fraud, waste or abuse:

- Facility fees and telehealth fees are billed for the *same* visit;

- The highest, most expensive level of telehealth services is billed *every* time;
- Telehealth services are billed for a *high number* of days in any given year;
- Medicare fee-for-service and a Medicare Advantage plan are billed for the *same* service for a high proportion of services;
- A *high average number* of hours of telehealth services are billed per visit;
- Telehealth services are billed for a *high number* of beneficiaries; and
- Telehealth services and ordering medical equipment are billed for a *high proportion* of beneficiaries.

Although the “high risk” providers submitted only a small percentage of the total number of claims for telehealth services, the amount of claims associated with these providers represented $127.7 million in Medicare fee-for-service payments. The Report also found that over half of the “high risk” providers were connected with at least one other “high risk” provider.

The OIG provided several recommendations to CMS:

- Strengthen monitoring and targeted oversight of telehealth services;
- Conduct additional education outreach to providers including training sessions, educational materials, and webinars on appropriate telehealth billing practices;
- Establish billing modifiers to help providers identify circumstances in which non-physician clinical staff primarily render telehealth services under the supervision of a physician;
- Identify telehealth companies that bill Medicare by updating the Medicare provider enrollment application or working with the National Uniform Claim Committee to add a taxonomy code that identifies telehealth companies; and
- Conduct targeted reviews of the “high risk” providers identified in the Report.

Final Thoughts

The importance of telehealth services cannot be understated. Under the current PHE, providers have had the opportunity to deploy these tools in the emergency context, and at the same time have been able to demonstrate their efficacy and reliability in providing quality medical care to patients who would not otherwise have access to either because of coverage or geographic limitations. Nevertheless, given the rapid growth of the industry in recent years and the amount of Medicare dollars spent on telehealth services, it is prudent for healthcare providers to proactively review their telehealth billing practices and supporting documentation. Doing so will reduce the potential for billing errors and minimize compliance risks while improving quality control and financially protecting their organizations.

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