OIG Report: Telehealth During the Public Health Emergency

BETSY NICOLETTI
SIMPLIFYING CODING FOR PHYSICIANS

Recorded February, 2024

What's an OIG report without doom and gloom?

Let's not look a gift horse in the mouth!

- Audit of E/M telehealth services done March 2020-November 2020
- 110 encounters, stratified sample
- Identified claims that used POS 02, or modifier 95, GT, GQ, G0

First, take a bow!

Congratulations to everyone who was working in medical practices and got the practice paid during 2020. It wasn't easy.

Of 110 records, 105 were accurate!

Results of this audit?

"This report does not have any recommendations because providers generally met Medicare requirements when billing for E/M services provided via telehealth and the unallowable payments we identified resulted primarily from clerical errors or the inability to access records."

Still, there were recommendations

- OIG noted time was not always documented--It's not required if using MDM
- From note, couldn't always tell if new or established patient
- OOPS! Some providers didn't sign the note.

Telehealth issues

Many of these have improved as we developed templates

- Not indicated if audio only, or audio/visual
- Didn't describe software used; currently HIPAA compliant software is required
- Some notes didn't note the location of the patient or provider

Not mentioned by the OIG, but my two suggestions

- Don't use a template with a physical exam!
- If using time, use visit time, don't include pre and post time

Reminded us of Documentation Guidelines

Specifically, the general guidelines in the 1995/1997 E/M guidelines

Let's review

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include: reason for encounter and relevant history, physical examination findings, and prior diagnostic test results; assessment, clinical impression, or diagnosis; plan for care; and date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

Let's review

4. Past and present diagnoses should be accessible to the treating or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

7. The CPT codes reported on the health insurance claim form should be supported by the documentation in the medical record.

Looking for the report?

"MEDICARE GENERALLY PAID FOR EVALUATION AND MANAGEMENT SERVICES PROVIDED VIA TELEHEALTH DURING THE FIRST 9 MONTHS OF THE COVID-10 PUBLIC HEALTH EMERGENCY THAT MET MEDICARE REQUIREMENTS." OIG, Feb, 2024. A-01-21-00501."

You can find it here:

https://oig.hhs.gov/oas/reports/region1/12100501.asp

Thank you

BETSY NICOLETTI
SIMPLIFYING CODING FOR PHYSICIANS

11

- www.betsynicoletti.com
- www.codingintel.com