U.S. Office of Personnel Management

Office of the Inspector General

Office of Audits

Final Data Brief

Evaluation of COVID-19's Impact on FEHBP Telehealth Services and Utilization

Report Number 2022-CAAG-0014
March 6, 2023

Executive Summary

Evaluation of COVID-19's Impact on FEBHP Telehealth Services and Utilization

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Why Did We Conduct the Evaluation?

During the Coronavirus Disease 2019 (COVID-19) pandemic, use of the Federal Employees Health Benefits Program's (FEHBP) telehealth benefit drastically increased. Specifically, we found that:

- Telehealth utilization increased more than 5,000 percent during the first 16 months of the COVID-19 pandemic; and
- Telehealth utilization continues to trend higher than pre-pandemic levels and we have no reason to believe it will ever return to pre-pandemic levels.

What Did We Evaluate?

We analyzed the FEHBP health insurance claims data from March 2019 through December 2021 for utilization trends and program integrity risks in telehealth claims. Additionally, we reviewed applicable regulations, all telehealth guidance issued to FEHBP carriers by the U.S. Office of Personnel Management (OPM), and FEHBP carrier responses to surveys related to telehealth services. Our evaluation was remotely conducted by our staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Our evaluation determined that:

- Some FEHBP carriers' claims processing systems do not perform edits or analytics to check for potentially fraudulent billing patterns that providers may use to inappropriately maximize their FEHBP payments for telehealth services;
- OPM Healthcare and Insurance has not set limits on which procedures are allowable via telehealth, increasing the risk that inappropriately billed procedures will go unidentified;
- There are very few controls in place to protect the confidentiality, integrity, and availability of the technologies used for telehealth sessions;
- Some carriers have no controls over recording audio or video during telehealth visits; and
- Some carriers do not educate FEHBP members or providers on telehealth privacy and security risks.

This data brief offers OPM and FEHBP participating health insurance carriers insights for improving telehealth policies and procedures and underscores the importance of covering and paying for telehealth services appropriately, implementing adequate program safeguards, and ensuring quality of care. Overall, the brief encourages OPM to consider centralizing guidance around telehealth in the FEHBP, due to the dramatic increase in utilization since the beginning of the COVID-19 pandemic and the resulting increased risks to FEHBP stakeholders.

Abbreviations and Definitions

Abbreviations

AMA	American Medical Association
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
Carrier	Health Insurance Carrier
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
FEHBP	Federal Employees Health Benefits Program
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HHS OCR	Health and Human Services' Office for Civil Rights
HIPAA	Health Insurance Portability and Accountability Act
OGC	Office of the General Counsel
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
RBCS Taxonomy	Restructured Berenson-Eggers Type of Service Classification System

Definitions

CARES Act	Signed into law in March 2020; provided over $2 trillion of economic relief to workers, families, small businesses, industry sectors, and other levels of government that have been hit hard by the public health crisis created by the Coronavirus Disease 2019.
Carrier or Health Insurance Carrier	Another name for a health insurance company; the term "carrier" is used interchangeably.
Carrier Letter	Instructions or guidance issued by OPM to contracted FEHBP health insurance carriers.

Council of the Inspectors General on Integrity and Efficiency	An independent entity established within the Executive Branch to address integrity, economy, and effectiveness issues that transcend individual Government agencies.
Community-Rated Health Maintenance Organization Carrier	A health insurance plan which allocates risks evenly across a community, based on the medical statistics of the community as a whole. (Also see FEHBAR 1602.170-2, 5b.)
Cost-Sharing	A general term used to refer to member out-of-pocket costs for the covered care received. May include deductibles, co-pays, and/or coinsurance.
CPT Codes	Current Procedural Terminology codes are a uniform language for coding medical services and procedures to streamline reporting and increase accuracy and efficiency.
Experience-Rated Fee-for Service Carrier	A rating that predicts a group's future medical costs based on its past experience that is the result of that group's actual paid claims, estimated claims, and other factors. (Also see FEHBAR 1602.170-7, 5a.)
Experience-Rated Health Maintenance Organization Carrier	A rating that predicts a group's future medical costs based on its past experience that is the result of the group's medical history and claims experience. (Also see FEHBAR 1602.170-7, 5a.)
HCPCS Codes	Healthcare Common Procedure Coding System codes are a collection of standardized codes that represent medical procedures, supplies, products, and services.
Health Savings Account	A type of savings account that allows a member to set aside money on a pre-tax basis to pay for qualified medical and other expenses. (Also see IRS Publication 969 (2021).)
HIPAA	Health Insurance Portability and Accountability Act of 1996: a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.
Impossible Hours	Provider billing for more than 24 hours of services in a 24-hour period.

Modifier Codes	Codes that indicate a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code.
Place of Service Codes	Codes used on health care professional claims to indicate the setting in which a service was provided.
Qualified High Deductible Health Plan	A plan with a higher deductible than a traditional insurance plan. (Also see IRS Notice 2019-45.)
RBCS Taxonomy	A taxonomy that allows researchers to group health care service codes into clinically meaningful categories and subcategories.
Telehealth	Health care provided remotely by means of telecommunications technology, including audio-only and/or audiovisual platforms.
Tukey Threshold	A standard mathematical technique used to identify extreme outliers in a dataset. The Tukey method traditionally sets the threshold at the 75th percentile plus 1.5 or 3 times the interquartile range. In this evaluation, we used 3 times the interquartile range.

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I. Background

The U.S. Office of Personnel Management (OPM) contracts with over 80 health insurance carriers (carriers) to provide health care benefits to more than 8 million federal employees, dependents, and eligible retirees 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.

The Coronavirus Disease 2019 (COVID-19) pandemic brought particular attention to telehealth as a means of limiting exposure to other individuals while receiving medical care, thereby minimizing the risk of contracting or spreading the virus. As mentioned in the OPM Office of the Inspector General's (OIG) October 1, 2021, through March 31, 2022, semiannual report,[1] telehealth utilization increased more than 5,000 percent over the first 16 months of the COVID-19 pandemic. The way in which members accessed these telehealth services also expanded during this time. In addition, OPM has stated that it will continue to focus on telehealth expansion, in part to address provider shortages within the mental and behavioral health specialties.

Telehealth procedures and operations are not centrally managed by OPM itself, but rather by individual FEHBP carriers or by each provider individually. Therefore, in response to the COVID-19 pandemic, OPM issued several Carrier Letters 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 waived member cost-share for COVID-19 testing and telehealth visits to minimize barriers to testing and treatment for FEHBP members. OPM also strongly encouraged carriers to focus on mental health, opioid use disorder, and substance use disorder benefits; leveraging telehealth expansion for rural populations and addressing provider shortages; and educating members regarding the availability of these 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. Because the administration of the telehealth benefit has been left up to the participating carriers and providers, little guidance has been issued by OPM as to its implementation and oversight.

Based on our assessment of the telehealth claims data we reviewed, we have no reason to believe telehealth will go back to pre-pandemic levels of utilization. This is our first evaluation of telehealth services as they relate to the FEHBP.

[1] https://www.oversight.gov/sites/default/files/oig-sa-reports/SAR66.pdf

II. Scope and Methodology

Scope

We reviewed multiple laws and regulations applicable to all FEHBP carriers, including the Coronavirus Aid, Relief, and Economic Security Act (CARES Act); the Families First Coronavirus Response Act; and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, we also reviewed 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 as well as the HHS Office for Civil Rights Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency. Moreover, we reviewed relevant Carrier Letters issued by OPM to FEHBP carriers to gain an understanding of OPM's telehealth guidance to FEHBP carriers. Finally, we performed an internet search for news articles related to telehealth in the FEHBP and reviewed the results.

Next, we issued a telehealth survey to 10 FEHBP carriers, covering 93 percent 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. The survey also included questions related to the safeguards carriers have in place to prevent fraud, waste, and abuse related to telehealth. These selected carriers cover a range of carrier size and type, providing services as either an experience-rated fee-for-service carrier, an experience-rated health maintenance organization carrier, or a community-rated health maintenance organization carrier. The carrier responses to our survey questions prompted follow-up questions to the carriers, as well as to OPM.

Finally, we analyzed FEHBP health claims data for the period of March 1, 2019, through December 31, 2021, from one of the larger nation-wide FEHBP plans which covers approximately 68 percent of the total FEHBP enrollment. For trend comparison purposes we broke this period down into the following categories:

Pre-COVID	COVID (First Year)	Extended COVID
3/1/2019 through 2/29/2020	3/1/2020 through 2/28/2021	3/1/2021 through 12/31/2021

Data Analysis Methodology

We conducted this evaluation in accordance with the Quality Standards for Inspection and Evaluation, also known as the Council of the Inspectors General on Integrity and Efficiency Blue Book.

For the purposes of this brief, we analyzed health insurance claims data from one large fee-for-service carrier to identify trends, patterns, and/or concerns of interest. We used the Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS)

codes, Modifier codes, and place of service codes listed in the table below to identify claims for services delivered via telehealth.

Place of Service Codes	02, 10
Procedure Codes	**CPT/HCPC Level 1 Codes:** 98966-98968, 98970-98972, 99091, 99421-99423, 99441-99443, 99453, 99454, 99457, 99458, 99473, 99474 **HCPC Level 2 Codes:** G0071, G0406-G0408, G0425-G0427, G0459, G0508, G0509, G2010, G2012, G2025, G2061-G2063, G2250-G2252, Q3014, T1014
Procedure Modifier Codes	95, GQ, GT, G0

All claims for telehealth services provided by physicians and non-physician practitioners during the time frames laid out in the scope section above were analyzed. Using this data, we determined the number of members 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 for these telehealth services.

To determine the most common telehealth services, we grouped each service into a category based on the Centers for Medicare and Medicaid Services' (CMS) Restructured BETOS Classification System (RBCS Taxonomy) and the CPT/HCPCS codes in our claims data. After creating these groupings, we calculated the number of telehealth services billed in each category.

To determine the proportion of members who received telehealth services from providers with whom they had an established relationship during March 2019 through December 2021, we removed those claims related to a specific plan code that indicated services were provided through the carrier's contracted telehealth company's portal (as opposed to a local provider portal). Members seeking services through this portal would not have had a prior relationship with their provider, because the portal assigns a physician to the patient at the time of service. This contrasts with 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. Any telehealth claims that were not assigned to this plan code were deemed to be telehealth claims where a member had an established relationship with the provider.

To describe the program integrity risks associated with telehealth, we developed nine measures as indicators of possible fraud, waste, or abuse. We developed these measures based on analyses of FEHBP claims data and input from OPM OIG investigators. These measures focus on

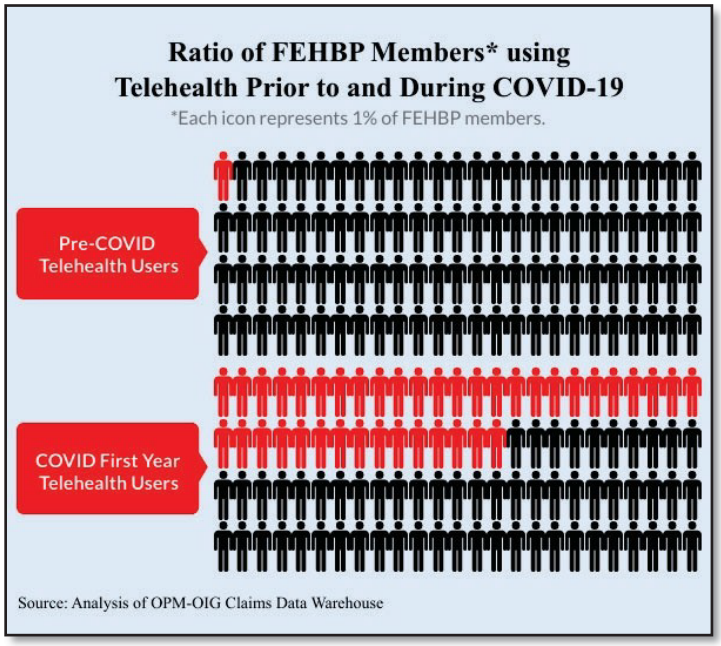
different types of telehealth billing schemes that providers may use to maximize their FEHBP payments. For each measure, we began by performing summary statistics on the relevant claim fields to determine an appropriate threshold for identifying unusual claims. This threshold was either the Tukey threshold, the 99th percentile, or another threshold as determined to be appropriate based on the professional judgement of the evaluator. For each measure, we set thresholds at extreme levels that may indicate possible fraud, waste, or abuse. We then analyzed FEHBP claims data 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 nine measures. The resulting list of providers and their associated billing patterns was forwarded to OPM OIG investigators for further review. We also reviewed all telehealth-related complaints made to the FEHBP fraud hotline. We ultimately did not identify any further risk measures from this review.

Lastly, we used the CMS 2021 RBCS Taxonomy categories and reviewed each category and sub-category to determine the likelihood that the services could or could not be performed via telehealth. Based on this assessment, we performed a query on our telehealth claims data set for those services we determined could not likely be performed via telehealth. To analyze the telehealth claim results, we created a pivot table to show the procedure codes, a count of the claim numbers, a count of the performing provider National Provider Identifier numbers, a sum of the allowed amount, and a sum of the amount paid.

III. Research Results

Telehealth Trend Data

Our analysis determined that utilization of telehealth services expanded significantly after the onset of the COVID-19 pandemic. During the first year of the pandemic, the number of unique FEHBP members who used telehealth services increased by nearly 3,000 percent compared to the prior year, telehealth claims increased by over 5,000 percent, and the amount paid by the FEHBP for telehealth services increased over 6,000 percent. FEHBP members most used telehealth for office visits and behavioral health services.



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

PRE-COVID	COVID First Year	Extended COVID
One percent of members used telehealth	40 percent of members used telehealth	24 percent of members used telehealth
Members received 148 thousand services via telehealth	Members received 8 million services via telehealth	Members received 5 million services via telehealth
Only one percent of all telehealth claims for our scope were incurred in the year prior to onset of covid-19	62 percent of telehealth services incurred during our scope were received after the onset of COVID-19	37 percent of telehealth services incurred during our scope were received throughout the remaining 10 months of 2021
Members most used telehealth for counseling, psychiatric care, and internal medicine service types.	Members most used telehealth for counseling and psychiatric care, internal medicine, and family practice service types.	Members most used telehealth for counseling and psychiatric care, internal medicine, and family practice service types.

Source: Analysis of OPM-OIG Claims Data Warehouse

Literature Review and Survey Results

As mentioned previously, in response to the COVID-19 pandemic, OPM also issued several Carrier Letters 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 waived cost-sharing for COVID-19 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; leveraging telehealth expansion for rural populations and addressing provider shortages; and educating members regarding the availability of these services.

OPM Carrier Letters Mentioning Telehealth Prior to and During the COVID-19 Pandemic

PRE-COVID	COVID-19 Pandemic
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.	**2020-02**: Issued March 2020 – OPM stated that encouraging members to use telehealth services would help limit the spread of the disease. Encouraged carriers to consider waiving cost sharing for testing and telehealth visits related to COVID-19.
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.	**2020-08**: Issued April 2020 – OPM stated 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.
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.	**2021-03**: Issued February 2021 – OPM stated that it and the carriers have worked and will continue to work together to ensure all FEHB 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.

PRE-COVID	COVID-19 Pandemic
2019-05: Issued April 2019 – OPM strongly encouraged carriers who offered a telehealth benefit to provide information regarding how telehealth was being used in mental health coverage and substance use disorder services.	**2021-05**: Issued April 2021 – 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). Encouraged carriers to expand telehealth to address rural populations that lack adequate providers for substance use disorder treatment services. Also encouraged the delivery of coordinated care leveraging telehealth technologies.
2020-01: Issued January 2020 – OPM reiterated assessing telehealth services for substance use disorder treatments.	

By supporting telehealth offerings, OPM and FEHBP contracted carriers have empowered members to safely access many types of health care services throughout the pandemic. Based on the above results of our telehealth trend analysis, we can confirm that FEHBP members' utilization of telehealth services greatly increased post-onset of the COVID-19 pandemic. These efforts by OPM and the carriers have helped to limit the spread of COVID-19, while allowing continuity-of-care for FEHBP members.

Although OPM has issued some telehealth guidance through the carrier letters outlined above, this guidance, mostly in the form of suggestions, would not necessarily result in consistent application of telehealth policies and procedures across FEHBP carriers. While some carriers appeared to provide guidance, policies, and oversight of telehealth services for and with their providers, other carriers appeared to be entirely reliant on individual providers, without applying any oversight of our guidance to these providers. Billing and processing of the telehealth claims also appears to be varied depending on the carrier, especially so because of various cost-sharing waivers and exceptions in place due to COVID-19 liberalizations. We determined that the possibility of telehealth providers being paid for non-covered or unnecessary services may be greater because edits and analytics intended to identify fraudulent billing schemes may be lacking for telehealth claims due to the waivers and exceptions granted. This may impact

HHS OCR Notification of Enforcement Discretion for Telehealth

"During the COVID-19 national emergency … covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies … may not fully comply with the requirements of the HIPAA Rules. OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules … ."

Source: HHS.gov

FEHBP members, who may not have been educated by the carriers on the various schemes and potential deceptions by providers, as they may be held liable for noncovered or unnecessary health services.

We would also like to highlight one other publication we reviewed during the research phase of this evaluation. In March 2020, the HHS Office for Civil Rights (HHS OCR) issued a Notification of Enforcement Discretion for Telehealth Remote Communications during the COVID-19 Nationwide Public Health Emergency. HHS OCR stated it would not impose penalties for noncompliance with the regulatory requirements of HIPAA during the pandemic. We are concerned that the lack of potential penalties may have allowed providers to slip in their compliance with HIPAA Rules over the last two-and-a-half years. Further, some providers may have only begun offering telehealth services after the pandemic began, when this enforcement discretion was in place, and therefore may never have evaluated whether their telehealth technologies comply with HIPAA rules. This is of particular concern to the FEHBP, because our survey results indicated that carriers rely heavily on HIPAA compliance as the primary measure to ensure telehealth technologies used by providers comply with appropriate privacy and security measures. Aside from HIPAA, we found that there is a lack of overall guidance from OPM itself and from FEHBP carriers specifically related to securing, maintaining, and monitoring telehealth technologies.

Finally, our review of the carrier survey responses prompted questions to OPM regarding telehealth guidance during the pandemic. We asked what involvement OPM had with benefit coverage changes, because the urgent nature of the pandemic required changes to be implemented mid-year, which does not typically occur during a standard benefit year. In particular, we asked what involvement OPM had in communicating these changes to the FEHBP members and what OPM's intent was when issuing the Carrier Letters that suggested waiving out-of-pocket costs for telehealth services, given that there was such a varied response by the carriers. We determined that OPM provided little guidance and direction to the carriers regarding what telehealth services could be provided and where and how those telehealth services were to be provided during the COVID pandemic. OPM instead relied on the carriers to do what was necessary; however, it did not provide any oversight on what was being done to ensure that FEHBP members were aware of the carriers' changes for telehealth services and whether FEHBP members were receiving satisfactory, safe, and secure telehealth services.

Program Integrity Measures

The results of the survey we issued also revealed potential weaknesses in telehealth claim processing procedures, which may have allowed fraudulent and/or abusive billing practices to go unnoticed. To determine whether these weaknesses were evident in the claim payment data, we identified nine program integrity measures and established an appropriateness threshold for each, as mentioned in the Data Analysis Methodology section above. Providers measuring above these thresholds would be considered anomalies and could indicate potential fraudulent billing practices. Overall, our analysis identified 691 unique providers whose billing patterns raised concerns. Of these, 71 providers showed up in multiple measures. As mentioned above, the list

of all providers identified was forwarded to the OPM OIG's Office of Investigations for further review, and this review is ongoing. The table below summarizes the results of our telehealth program integrity analysis.

Analysis of Telehealth Program Integrity Measures

Measure Name	Description	Number of Providers Above Threshold
Copays Charged	Providers charging co-pays over $120	128
Minutes per Visit	Providers billing more than 180 minutes per visit	2
Lines per Claim	Providers averaging more than 10 lines per claim	14
Days Telehealth Billed in a Year	Providers billing telehealth for more than 300 days in a year	92
Unique Members Billed per Provider	Providers billing over 2,000 unique members in a year	146
Unique Procedure Codes Billed per Provider	Providers billing over 100 distinct procedure codes	24
Billing Unrelated to Specialty	Providers billing for procedures unrelated to their specialty	147
Percentage of Patients Billed at Far Distances	Providers billing over 88 percent of claims for members located more than 116 miles from the provider	202
Billing All Visits at Highest Complexity Level	Providers billing all visits at the highest complexity level, according to procedure code groups for various visit types. Provider billing was narrowed to office visits (none found for nursing facility, assisted living facility, or home visits).	28

Source: Analysis of OPM-OIG Claims Data Warehouse

In addition to the above measures, we also scrutinized telehealth procedures that we determined were unlikely to be legitimately performed via telehealth. This analysis identified over 2,000 claims paid for 247 unique procedure codes billed as telehealth that we determined could not be performed via telehealth (e.g., skin debridement and colonoscopies.) While telehealth is not a new offering in the FEHBP, the variety of services offered and the technologies utilized have increased. When combined with the overall increase in telehealth utilization, we believe increased scrutiny and increased protections are both warranted moving forward.

IV. Findings and Recommendations

1. Telehealth Claims Edits and Analytics: Procedural

Our review of telehealth claims found a variety of potentially fraudulent billing patterns that are not addressed by some FEHBP carriers' system edits or claim analytics.

We found that each participating FEHBP carrier is responsible for administering its own telehealth benefits, including implementing appropriate integrity safeguards. OPM does not prescribe any required system edits, audits, or reviews to be performed on telehealth claims. While carriers do typically have system edits in place for duplicate payment identification, medical necessity reviews, upcoding, and coordination of benefits, the results of our telehealth carrier survey revealed that some carriers have waived some of these edits for telehealth claims. Further, most carriers we surveyed do not have edits in place to check for impossible hours for telehealth providers.

An analysis of the OPM OIG's claims data warehouse identified a variety of patterns that could indicate potential fraud that was not caught by system edits. For example, we identified several providers who were billing most of their telehealth claims for patients located very far from themselves, billing for procedures incompatible with their specialty (e.g., a psychologist billing for dialysis), or billing a much higher number of unique patients per year, as compared to the average provider.

Excerpt of Suspicious Billing Patterns Analysis

Billing a High Percentage of Patients at Far Distances: 202 providers

Billing Incompatible with Provider Specialty: 147 providers

Billing an Unusually High Number of Unique Patients: 146 providers

While none of these instances has yet been confirmed as fraudulent, implementing edits and analytics to identify these types of patterns would decrease the likelihood of fraudulent billing going undetected. Should no actions be taken, this continued lack of thorough claims system edits and/or appropriate audits, reviews, or analytics increases the risk to the FEHBP from fraud, waste, and abuse.

Recommendation 1:

We recommend that OPM direct carriers to review their claims system edits as they relate to telehealth claims and to implement appropriate claim audits and/or data analytics to identify potentially fraudulent, wasteful, or abusive telehealth billing practices.

OPM's Response:

OPM stated that it does not concur with the factual accuracy of this finding nor with the recommendation. It believes that the data collected and reviewed by the OIG is not

complete, comprehensive, or representative of all FEHBP carriers, as only 10 carriers were surveyed and data of only one carrier was reviewed. Additionally, it does not believe that the data reviewed was detailed enough to support the conclusion expressed for any one carrier or across the FEHBP. ***(Note: OPM restates this identical argument for each recommendation. It will not be repeated in full going forward.)***

OPM also disagrees with the OIG's conclusions regarding impossible hours. Based on its review of the OIG's survey response summary, it believes that most carriers have impossible hour edits in place and stated "…of the responses that are completely developed it appears that 6 of 7 carriers have impossible hour edits, or 86% of the carriers surveyed do have impossible hours edits."

OPM further disagrees with OIG's conclusion that some carriers have waived some edits related to duplicate payment identification, medical necessity reviews, upcoding, and coordination of benefits. While the carriers may not use specific telehealth edits, they do have other controls in place. It also disagrees with the use of the term "waived" since those carriers noted they have other controls.

Finally, OPM disagrees with the OIG's conclusion that patterns identified indicate that potential fraud was not caught by the system edits. It states that it doesn't appear as if the evaluation has found evidence of fraud from the carrier data. It goes on to state that its carriers are required by contract to have robust fraud, waste, and abuse program and that telehealth claims should be part of it. OPM noted that for the determination of fraud to be made further investigation would be needed and it welcomed the OIG to conduct such an investigation.

OIG Comments:

As stated above, we believe the work performed as part of this evaluation, as described in the methodology section of this brief, was sufficient to arrive at our conclusions and the need for corrective actions. Though we only surveyed 10 carriers, these carriers represented a variety of types and sizes of carriers and, in total, covered 93 percent of total persons covered by the FEHBP. In addition, the data we reviewed, while only for a single carrier, also covers 68 percent of covered persons during the evaluation period and was used primarily to support our findings from our literature review and survey responses.

As previously explained to OPM via email, it has misinterpreted and apparently rejected the explanation of our summary of the survey responses as they relate to the impossible hours edits. Only three carriers indicated that they have edits for impossible hours (30 percent of carriers surveyed). As to our language regarding the waiving of specific telehealth edits, some carriers indicated in their survey responses that certain edits are given telehealth exceptions. Thus, these edits are waived for telehealth claims.

We do not purport that we have found, investigated, and tried any specific instances of fraud. That would be outside of the scope of this evaluation. As mentioned previously, instances of suspected fraud were forwarded to the OIG's Office of Investigations for further review.

Nonetheless, we stand by our conclusions that the patterns we identified in the claims data do suggest the potential for fraudulent billing to go unnoticed. We believe there is value in implementing preventive controls, rather than leaving program weaknesses unresolved and waiting for adverse events to occur. Thus, our recommendation for carriers to review their telehealth claims edits is warranted.

2. Telehealth-Eligible Services: Procedural

Our review of telehealth claims found that OPM has not set limits on which procedures are allowable via telehealth for the FEHBP carriers to follow.

Currently, each participating FEHBP carrier is responsible for administering its own telehealth benefits, including implementing appropriate program integrity safeguards. OPM does not place program-wide restrictions on the types of services eligible to be performed via telehealth. In response to our survey of 10 carriers, we found that most carriers had expanded telehealth services covered due to the COVID-19 pandemic, though specific types of services covered varied greatly, and some carriers planned to continue covering these expanded telehealth services regardless of the status of the pandemic.

During our review of claims data for this evaluation, we observed a pattern of claims submitted with either a telehealth modifier code or place of service indicators which ostensibly could not physically be performed via telehealth. 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 overall.

Examples of Procedure Codes Submitted as Telehealth Claims

Procedure Code	Description
00830	Anesthesia for hernia repairs in lower abdomen
10060	Incision and drainage of abscess; simple or single
11000	Debridement of extensive eczematous or infected skin; up to 10 percent of body surface
11721	Debridement of nail(s) by any method(s); 6 or more
17000	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions; first lesion
17003	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions; second through 14 lesions, each
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles

Procedure Code	Description
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); without ultrasound guidance
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
31575	Laryngoscopy, flexible; diagnostic-the flexible laryngoscope inserted through the nose, advanced into the pharynx and the vocal cords, tongue base, and hypopharynx are examined diagnostically for signs of disease or injury.
36415	Collection of venous blood by venipuncture - assign code 36415 only once per encounter even if multiple venipunctures are performed.
45380	Colonoscopy, flexible; with biopsy, single or multiple

We determined that the varied responses, across just 10 of the FEHBP health insurance carriers that cover 93 percent of our membership, is due to the lack of specific guidance from OPM to the FEBHP carriers regarding procedures that could realistically be performed via telehealth. For the Medicare program, CMS maintains a list of services (identified by procedure code) that are payable when furnished via telehealth.[2] Any claims for procedure codes not on this list billed with telehealth places of service or modifier codes will not be paid. The lack of such guidance from OPM for the FEHBP may put FEHBP members and the FEHBP itself at risk of overpaying for telehealth services due to suspicious billing practices, such as billing for services not rendered or that could not be performed via telehealth, upcoding, or impossible day scenarios.

Discussion with OPM indicated that it requires carriers to adjudicate claims based on clinical appropriateness and that the regulations that govern the practice of medicine are the responsibility of state medical boards. In response, we would first refer to the above-mentioned issues we uncovered when reviewing telehealth claims data. Unfortunately, OPM's requirement of carriers to review claims based on clinical appropriateness does not seem to currently be preventing claim payments for services that appear to be inappropriately billed as telehealth. As such, we do not believe that relying on state regulations is sufficient to prevent the types of billing errors we identified in our review. Further, as demonstrated by CMS, it is possible to maintain a list of telehealth-eligible services for program members without interfering with the responsibilities of state medical boards.

Recommendation 2:

We recommend that OPM develop and maintain a list of services that can be provided via telehealth and require carriers to place edits in their claims systems which will check telehealth claims against this list. Any telehealth claims with procedure codes indicating services not on this list should pend for medical review prior to payment. OPM could start with the list maintained by CMS, expanding the allowed services if desired.

[2] https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

OPM's Response:

As it did with Recommendation 1, OPM stated that it does not concur and does not agree with the factual accuracy of this finding nor with the recommendation. ***(See OPM's response to Recommendation 1 for the full response.)***

OPM also "does not agree with the OIG's conclusion that there is a lack of restrictions or review placed on telehealth claims in the FEHBP … ." OPM goes on to state that while most FEHBP carriers surveyed have telehealth edits in place, that all are required to have system edits in place to prevent erroneous payments, and that it requires carriers to adjudicate claims based on clinical appropriateness, medical necessity, and prudent business practices. It further disagrees that its carriers' systems are not preventing inappropriate services to be billed as telehealth.

OPM states that the varied responses received by the OIG to its survey questions is not the result of the lack of specific guidance from OPM, but the nature of health care governance and regulations varying from state to state as it explains below.

"Between Medicaid and private insurance, over three-quarters of Americans purchase health insurance regulated at the state level. State telehealth laws frequently note that no two states have the same regulations when it comes to coverage and payment. States range from having no telehealth parity laws that specify which telehealth services are covered and their reimbursement rate, to having full coverage and payment parity for telehealth services. Most states have similar telehealth rules for Medicaid and private payers but there are some exceptions. For instance, private insurance can generally reimburse for telehealth when the patient is at work or at home, while several states' Medicaid guidelines specify that care must be delivered in a qualified health-care facility to be reimbursed. While the federal government can promote telehealth coverage in the population it serves by changing rules for Medicare and by setting minimum coverage standards for Medicaid, state insurance regulators, Medicaid agencies, and medical boards can all changes rules for practice, coverage, and reimbursement for the use of telehealth services for those not insured through federal programs. OPM is not a direct provider or payor of health care services. The Federal Employees Health Benefits Act, 5 U.S.C. §8901 et seq., authorizes OPM to enter into contracts with private insurance carriers to administer and insure benefit plans. Therefore, a list such as that established by CMS, would not be appropriate in the context of FEHB since private insurance is controlled by state laws. Further, OPM does not regulate the practice of medicine. FEHB Program members receive medical services from providers that are bound by state provider regulations. A list of telehealth-eligible services for program members would need to be on a state-by-state basis, which state regulators and medical boards have implemented.

The OIG references CMS's list of Medicare-covered services that can be received through telehealth and notes that OPM does not have such a list. The OIG concludes that OPM's

lack of a specific list of covered services 'may put FEHBP members and the FEHBP itself at risk of overpaying for telehealth services due to suspicious billing practices, such as billing for services not rendered, upcoding, or impossible day scenarios.' For the reasons we've previously stated, we do not agree with this conclusion."

OIG Comments:

OPM fails to directly address our concerns (and not outright conclusions), that anesthesia, wound debridement, injections, and colonoscopies are not procedures that can be performed via telehealth. OPM has not addressed how any of these types of procedures are (or could be) telehealth related and expressed no concerns of its own in its response.

After receiving OPM's response to this recommendation, we reached out to one large carrier (covering 68 percent of the FEHBP) asking it to review several claims from our analysis results to determine whether they were paid appropriately. In response, the plan indicated that all claims examined were paid incorrectly and that none of the claims pended for further review, despite the procedure codes listed on the claim lines being potentially incompatible with the telehealth modality. While OPM may require carriers to adjudicate claims based on clinical appropriateness, medical necessity, and prudent business practices, our review of telehealth claims paid by a large FEHBP carrier indicated that these requirements are not sufficient or not sufficiently enforced.

As stated by OPM, some states have no telehealth parity laws that specify which telehealth services may be covered and which may not. This leaves the FEHBP and its members in these states vulnerable to inappropriate billing schemes.

In March 2022, OPM itself recognized, "the law governing the FEHB Program at 5 U.S.C. section 8902(m) gives FEHB contract terms preemptive authority over state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits." Accordingly, OPM has in the past used its contracting authority to advance certain health care initiatives, regardless of state-level regulations. For example, since 2016, OPM has required that no FEHBP carrier have a general exclusion of services, drugs, or supplies related to the treatment of gender dysphoria. This is in opposition to the variation in state regulations, some of which explicitly exclude transgender health coverage and care.

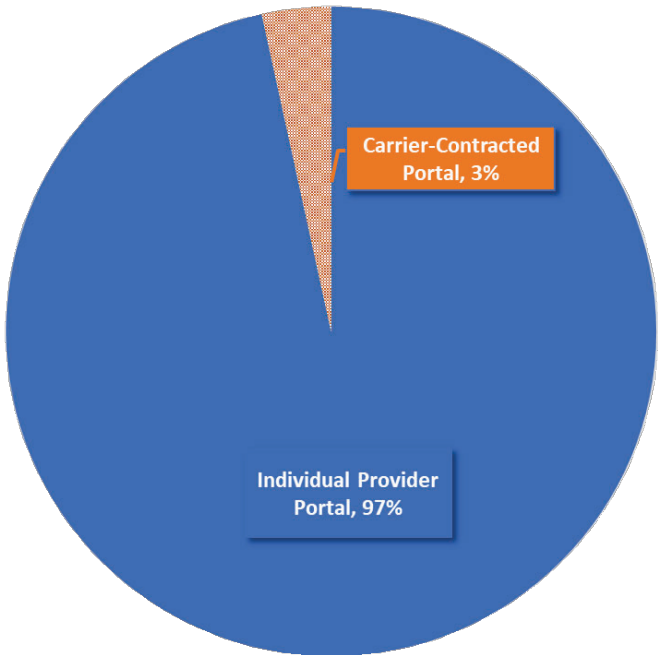
On the other hand, OPM has also used its contracting authority to advance certain health care initiatives while implicitly and explicitly recognizing that state-level authorities may shape the benefits provided by the carriers. For example, in 2021, OPM encouraged FEHBP carriers to offer coverage for fertility preservation in members undergoing medical therapies that are likely to result in infertility. However, OPM also specified that benefit proposals submitted by carriers, "should comply with state guidelines and clearly indicate benefit limitations and exclusions."

OPM could issue guidance which appropriately navigates or supersedes the various state-level authorities which apply to telehealth, as it has done in the past in regard to other types of services.

3. Telehealth Technology Requirements: Procedural

Our review of FEHBP carriers' telehealth programs found that there are very few controls in place to protect the confidentiality, integrity, and availability of the technologies used for telehealth sessions.

While OPM has pointed carriers towards telemedicine accreditation standards published by the American Telemedicine Association and URAC,[3] OPM has not issued any actual requirements for telehealth portal acceptability. Responses to our carrier telehealth survey indicated that while carrier-contracted telehealth portals typically employ a great deal of appropriate privacy and security measures, there are very few requirements in place for local provider telehealth portals. Providers may use essentially any technology they desire to perform their telehealth services, frequently with little, if any, requirements for technology standards or security considerations. 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 abiding by relevant requirements. This is particularly concerning because our review found that only 3 percent of telehealth claims occurred via a carrier-contracted portal, while 97 percent occurred via a local provider portal.



Further, in response to our telehealth survey questions, many carriers and OPM referenced HIPAA as the main privacy regulation with which FEHBP providers must comply. However, in March 2020, HHS issued a notice of HIPAA enforcement discretion for telehealth communications during COVID-19.[4] This notification acknowledged that some telecommunication technologies may not fully comply with the requirements of the HIPAA rules and stated that HHS would not impose penalties for noncompliance with these regulatory requirements in connection with the good faith provision of

[3] https://www.opm.gov/healthcare-insurance/healthcare/carriers/2016/2016-03.pdf
[4] https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

telehealth during the COVID-19 public health emergency. As such, FEHBP providers have been held to no specific telehealth privacy and security requirements for over two years.

Not requiring specific standards for telehealth technologies increases the risk that providers will utilize unstable and/or insecure telehealth platforms. Not all technologies are controlled appropriately for the highly sensitive nature of personal health information, nor are proper measures taken to ensure constant system availability, as would be desired for a health care platform. Some technologies may be more vulnerable to natural disasters, system overload, or threat actors seeking to exploit system weaknesses for malicious purposes.

The lack of specific telehealth technology requirements in place for FEHBP providers increases the risk that the telehealth portal may be unavailable when needed and that FEHBP member personal and health information may be unintentionally exposed.

OPM claimed during discussions that we do not acknowledge that a national emergency continues and expressed concern that local providers may not have the technical abilities needed to meet HIPAA requirements, which will result in members not receiving care. On the contrary and as expressed to OPM multiple times in meetings and in writing, our concern is that after more than two years, the pandemic continues, and we do not have any way of knowing when it will end. For this reason, we believe that we need to begin moving toward secure telehealth platforms to protect the privacy and security of our members, alongside protecting their physical health.

Recommendation 3:

We recommend that OPM specify the telehealth technology laws and regulations with which FEHBP providers must comply or create its own list of requirements, if preferred, and require FEHBP carriers to ensure providers are implementing these requirements.

OPM's Response:

As it did with Recommendation 1, OPM stated that it does not concur and does not agree with the factual accuracy of this finding nor with the recommendation. ***(See OPM's response to Recommendation 1 for the full response.)***

OPM also disagrees that there are few controls in place over technologies used for telehealth sessions. It states that the laws of the various states, HIPAA and other Federal laws would apply to health care providers whether the benefit was provided via telehealth or in-person.

"Further, the OIG states that they have expressed to OPM multiple times that their concern is that if the pandemic does continue, OPM should require FEHB Carriers to ensure more secure telehealth platforms to protect the privacy and security of our members. The Notification of Enforcement Discretion for Telehealth Remote

Communications during the COVID-19 Nationwide Public Health Emergency was issued by the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS). OCR is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability act of 1996 (HIPPA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act to protect the privacy and security of protected health information. This notice allowed health care providers to use widely available communications software without fear of violating HIPAA, even if the software does not meet the HIPAA privacy and security requirements."

The "OCR states that they believe many current and commonly available remote electronic communication products include security features to protect electronic protected health information (ePHI) transmitted between health care providers and patients. In addition, OCR believes that video communication vendors familiar with the requirements of the Security Rule often include stronger security capabilities to prevent data interception and provide assurances they will protect ePHI by signing a HIPAA business associate agreement (BAA).

Providers seeking to use video communication products are encouraged to use such vendors but will not be penalized for using less secure products in their effort to provide the most timely and accessible care possible to patients during the Public Health Emergency. Further the Notice states that providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications."

The "OCR also took into account the remote communication product. They are saying 'non-public facing' remote communication products can be used. Non-public facing remote communication products include, for example, Apple FaceTime, Facebook Messenger video chat, Google Hangout video, Whatsapp Videochat, Zoom, or Skype. Typically, these platforms employ end-to-end encryption which only allows an individual and the person with whom the individual is communicating to see what is transmitted. The platforms also support individual user accounts, logins, and passcodes to help limit access and verify participants. In addition, participants are able to assert some degree of control over particular capabilities, such as choosing to record or not record the communication or to mute or turn off the video or audio signal at any point. The OIG did not take into account the current security of the platforms used or the OCR's discretion when analyzing the technology requirements."

In its report, "the OIG discounts HHS's guidance, does not acknowledge that a national emergency continues and that many local providers may not have the technical abilities needed to meet HIPAA requirements. This could result in members not receiving care, arguably a far greatest risk, with potentially grave[r] consequences than any discussed in this … Data Brief. FEHB Carriers have no control over out of network, non-contracted providers. Further, once the current COVID-19 public health emergency declaration ends,

the Consolidated Appropriations Act of 2022 has ensured a 151-day extension period for many of the policies outlined in the COVID-19 public health emergency declaration to allow for a transition period. This includes telehealth platforms. In addition, ongoing efforts to expand telehealth beyond the pandemic persist in pending bills such as the Telehealth Extension Act, Cures 2.0 Act and Protecting Rural Telehealth Access Act, all of which seek to make existing telehealth flexibilities permanent. Concerning the modality of telehealth, the federal government has introduced a bill to standardize telehealth modality options such as Ensuring Parity in MA and PACE for Audit-Only Telehealth Act of 2021 or the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021. During this transition phase OPM believes it should wait to determine what the federal and state laws initiate on telehealth technology. If OPM issued guidance that opposes HHS's requirements, it could result in a lack of continuity of care and would be a barrier to FEHB members receiving healthcare during a time when provider offices were not seeing patients in-person. Furthermore, the OIG is inviting confusion among carriers if they are asked to follow multiple sets of standards issued by the Federal government."

OIG Comments:

Laws and regulations are not synonymous with controls. When we say, "there are very few *controls* [emphasis added] in place to protect the confidentiality, integrity, and availability of the technologies used for telehealth sessions," we are referring to policies, procedures, and technical safeguards implemented by carriers and providers to comply with applicable regulations. The results of the survey we issued to carriers indicated that they had very few such policies and could not validate whether providers had adequate telehealth technology controls in place.

We do not agree that this recommendation would require OPM to issue guidance in opposition to HHS, HIPAA, or any other federal guidance. We simply recommend that OPM specify which existing telehealth technology laws and regulations FEHBP providers should follow and ensure this is verified by FEHBP carriers. It is not unusual for technology laws and regulations to evolve at a more rapid pace than other laws and regulations, simply due to the nature of technology. However, we do not feel that waiting an unknown period of time for the pandemic to end and a new telehealth law to possibly be enacted is the best course of action for protecting FEHBP members.

4. Consent to Record Telehealth Sessions: Procedural

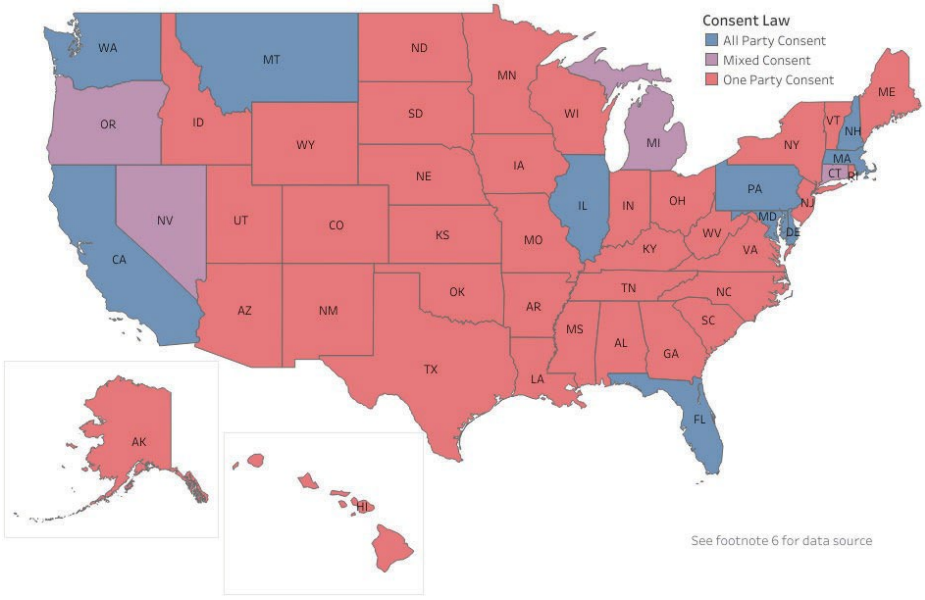
Our review of FEHBP health insurance carriers' telehealth programs found that some carriers had no controls over recording audio or video during telehealth visits.

In response to our survey of 10 FEHBP health insurance carriers, some carriers simply stated that provider agreements require providers to be in compliance with applicable state and federal laws and regulations, including HIPAA. Additionally, some carriers stated that their contracted

telehealth portals do not record audio or video visits by design. However, telehealth services obtained via these contracted portals make up only a small portion of telehealth services. Most telehealth visits are performed via a local provider portal, over which the carriers have no control.

One carrier indicated in its survey response that standard HIPAA guidance stipulates audio or video visits should not be recorded unless otherwise agreed to by the member and provider. However, we have great concern over the carriers' reliance on HIPAA, given the enforcement discretion in place and because we could find no language in HIPAA specifically regarding informed consent to record sessions, telehealth or otherwise. We believe the confusion on the part of this carrier highlights the need for centralized guidance for FEHBP members and providers.

In general, the legality of both audio and video recording varies by state, with only 10 states requiring informed consent to record audio from all parties to a conversation.[5] In the other 40 states and the District of Columbia, only one party is required to consent.[6] However, some of these other 40 states have more complicated laws regarding consent to record. For example, in Nevada, in-person oral conversations require consent only from one party, but wired communications require consent from all parties.[7] In Oregon, the exact opposite applies.[8] Given that the FEHBP is administered across the country and that telehealth in particular often occurs across state lines, the variation in state laws may cause confusion for providers and patients



This map summarizes the consent to record laws for each state in the U.S. There are 10 states that require consent to record from all parties to a conversation, including California, Delaware, Florida, Illinois, Maryland, Massachusetts, Montana, New Hampshire, Pennsylvania, and Washington. Four states have more complex consent laws, requiring all party consent in some circumstances and one party consent in others. These states include Connecticut, Michigan, Nevada, and Oregon. The remaining 36 states and the District of Columbia have one party consent laws.

[5] This report is intended only to provide a general overview of some of the authorities which may impact telehealth. Because these authorities change frequently, this report may not necessarily contain the most up-to-date information at the time of reading. Please note that this report is not intended to provide legal advice and should not be construed as legal advice.

[6] *See, e.g.,* 1 James G. Carr & Patricia L. Bellia, *Law of Electronic Surveillance*, § 3:59 (Nov. 2022 ed.)

[7] Nev. Rev. Stat. Ann. §§ 200.620, 200.650.

[8] Ore. Rev. Stat. Ann. §§ 165.540(1)(a), 165.540(1)(c).

about their rights and responsibilities in regards to recording sessions. Further, it should be noted that in those states which do require informed consent from all parties, patients may face legal consequences if they record their own telehealth sessions without first obtaining consent from the provider.[9] In the day of screen-recording applications and smartphones with recording capabilities, it is important for FEHBP members to be aware of this and understand the legal requirements for recording.

Lastly, the American Medical Association (AMA) recommends restricting any recordings to only those sessions which are held with patients who have decision-making capacity. The AMA recomends that if recording must occur for other individuals, informed consent should be acquired from the individual's legal guardian, parent, or authorized decision-maker.[10]

The lack of FEHBP-specific guidance concerning recording audio or video during telehealth visits may put FEHBP members' protected health information and personally identifiable information at risk of inappropriate exposure and may open FEHBP members and providers up to legal repercussions.

OPM responded in discussions that providers are subject to the laws of the state in which they practice, and that it would cause unnecessary confusion for a provider to administer a different standard depending on whether the member was in the FEHBP or a different health group. For the reasons outlined above, we believe telehealth presents unique concerns regarding the administration of a nationwide health insurance program. Given that telehealth sessions occur via technology rather than in person, the member and the provider may not necessarily know in which state the other is located. We believe this places undue burden on both the provider and the member to be familiar with the laws concerning recording other parties in all 50 states. Therefore, we do not believe that requiring informed consent for recording FEHBP member sessions would cause any greater confusion than already exists.

Recommendation 4:

We recommend that OPM consult with the Office of the General Counsel (OGC) to determine the legal sufficiency of OPM's preemptive authority to implement a uniform framework requiring FEHBP providers to obtain informed consent from all parties before recording audio or video telehealth sessions.

Should OGC conclude that OPM's preemptive authority is not sufficient to require FEHBP providers to obtain informed consent in all circumstances, then we recommend that OPM issue guidance to FEHBP carriers recommending that FEHBP providers obtain informed consent, where required by existing and applicable authorities.

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9 https://publications.aap.org/aapnews/news/13600?autologincheck=redirected

10 https://www.ama-assn.org/delivering-care/ethics/audio-or-visual-recording-patients-education-health-care

Regardless of OGC's determination, we also recommend that the guidance OPM sends to the FEHBP carriers should require them to educate members about the importance of informed consent regarding telehealth visits, both when a provider wishes to record and if a member wishes to record their own session.

OPM's Response:

As it did with Recommendation 1, OPM stated that it does not concur and does not agree with the factual accuracy of this finding nor with the recommendation. ***(See OPM's response to Recommendation 1 for the full response.)***

OPM states that providers are subject to the laws of the state where they practice medicine and that the Privacy Rule protects all health information transmitted by a provider. Due to differing state laws, "OPM cannot issue specific guidance that would fit all FEHB Program carriers. It would cause additional and unnecessary confusion for a provider to administer a different standard depending on whether the member was in the FEHB Program or a different health group.

As noted above, we have several concerns with the recommendation: it discounts HHS and HIPAA guidance and does not acknowledge that a national emergency continues. The OIG is inviting confusion among carriers were they to be asked to follow multiple sets of standards issued by the Federal government. It would be especially inappropriate to issue guidance in opposition to HHS guidance as recommended by the OIG during the ongoing national emergency."

OIG Comments:

We are not recommending that OPM issue guidance in opposition to HHS, HIPAA, or any other federal government regulations. We are not aware of any federal guidance that has been issued which would prohibit providers from obtaining informed consent before recording.

Finally, as mentioned above, the existence of regulations does not ensure that controls have been put in place to comply with all relevant regulations. In fact, in response to our survey, one carrier responded, "We would expect our providers rendering care (including via telehealth) to comply with all applicable laws and requirements, but we as a health plan do not have any specific policies around the recording of a telehealth visit." Just because a framework of state and federal authorities governs the provision of telehealth, does not mean that carriers have developed and implemented policies, procedures, or administrative safeguards that verify compliance with these authorities.

5. Telehealth Guidance for FEHBP Members and Providers: Procedural

Our review of FEHBP health insurance carriers' telehealth programs found that some carriers do not educate FEHBP members or providers on telehealth privacy and security risks.

OPM has left all telehealth guidance for members and providers up to the carriers to issue, without specifying any required guidance that should be sent. Unfortunately, several of the FEHBP carriers we surveyed indicated that they do not educate providers on telehealth concerns such as privacy and security risks. In addition, the results of our review indicated that the burden is largely on FEHBP members themselves to identify suspicious billing practices, privacy and security concerns, or quality of care issues related to telehealth services and report these to their carrier or to the OPM OIG health care fraud hotline. Since we cannot expect all FEHBP providers to be cybersecurity experts, nor can we expect all FEHBP members to be billing and quality control experts, the current lack of guidance increases the risk that member harm will occur and go unidentified.

FEHBP members would be better protected if both the members themselves, as well as FEHBP providers, were educated on methods to reduce telehealth risks and identify potential harms when they occur. For example, OPM could encourage members and providers to be aware of their surroundings, such as ensuring they are in a private location and connected to a private wireless network before beginning the session. OPM could also encourage members to verify the provider's identity and credentials before beginning a session, and to review their Explanation of Benefits documents for inaccuracies after a session. The AMA's Telehealth Implementation Playbook[11] would be a great resource for OPM to utilize when developing guidance for FEHBP providers, while HHS' guidance on telehealth privacy for patients[12] would be a good starting point for members.

Examples of Recommended Telehealth Guidance for Providers and Members

Provider Best Practices	Member Telehealth Reminders
Verify who you are to the patient and verify the patient's identity.	Verify the provider's identity at the beginning of the visit.
Ensure privacy throughout the visit.	Ensure privacy throughout the visit.
Establish and document telehealth security policies and procedures for your practice.	Find a quiet space where you will feel comfortable speaking openly to the provider.
Conduct a privacy and security risk assessment on your current telehealth environment.	Protect your wireless connection with a secure password.
Consistently and regularly train all staff in privacy and security policies and procedures.	Avoid accessing telehealth on networks/devices shared with people outside of your home, including public Wi-Fi networks.

[11] https://www.ama-assn.org/system/files/ama-telehealth-playbook.pdf
[12] https://telehealth.hhs.gov/patients/telehealth-privacy-for-patients/

Provider Best Practices	Member Telehealth Reminders
Familiarize yourself with Federal, State, and Local telehealth laws.	Keep your devices updated and protect your devices with antivirus software.
Verify whether your telehealth platform of choice undergoes third-party audits/certifications, complies with your local regulations, and provides transparency on collected data use cases.	Review your benefit brochure and/or call your carrier to understand what medical services are covered and not covered.
Encrypt data in motion and at rest.	Review and understand your Explanation of Benefits after each of your visits.

As stated above, the lack of guidance sent to FEHBP members and providers regarding telehealth risks increases the risk that member harm will occur and go unidentified. This harm could occur in the form of care interruption, if a patient or provider is unaware of how to establish a sufficient internet connection; a privacy breach, if a patient or provider does not consider their location for the visit or if the technology used is vulnerable to eavesdropping; or financial harm could occur if a patient does not understand how to interpret their Explanation of Benefits after a visit. Guidance on these types of telehealth concerns would improve the safety and security of telehealth services in the FEHBP.

OPM stated in discussions on this finding that it has not identified any unique risks associated with telehealth that would require specific guidance nor does it agree that it should take on a role that HHS does not require. The fact that OPM has not identified any unique risks does not mean that guidance is not necessary. This is further supported by the fact that other experts, such as the AMA and HHS, have already found it necessary to issue the exact type of guidance we are suggesting OPM issue. To OPM's second point, it is not our opinion that OPM should administer the FEHBP by doing only that which is "required" of them by some external organization. Given the sudden, drastic increase in telehealth utilization over the past couple of years combined with the concerns laid out in these findings regarding the general lack of controls over telehealth and the associated risks to the program, we would question why OPM would not want to take action which would cost little and would greatly increase the integrity of the FEHBP and better protect all its participants.

Recommendation 5:

We recommend that OPM direct its carriers to issue guidance to members and providers on telehealth billing, privacy and security, and quality of care risks.

OPM's Response:

As it did with Recommendation 1, OPM stated that it does not concur and does not agree with the factual accuracy of this finding nor with the recommendation. ***(See OPM's response to Recommendation 1 for the full response.)***

Additionally, OPM states that telehealth is not a new benefit. It does not feel that any risks associated with telehealth, requiring specific guidance, have been identified by the data brief.

OIG Comments:

While telehealth is not a new benefit, utilization of this benefit has increased more than 5,000 percent since the beginning of the COVID-19 pandemic. Therefore, it is a new benefit to much of the FEHBP population as it had been underutilized prior to the start of the pandemic. This, along with the concerning trends identified in this data brief, warrants the implementation of telehealth-specific guidance for FEHBP members and providers.

Appendix

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
1900 E Street, NW, Washington, DC 20415

Healthcare and Insurance

Date: September 15, 2022

Memorandum for: Michael R. Esser
Assistant Inspector General for Audits

From: Laurie E. Bodenheimer
Associate Director, Healthcare and Insurance

LAURIE BODENHEIMER
Digitally signed by LAURIE BODENHEIMER
Date: 2022.09.15 16:09:24 -04'00'

Mark W. Lambert
Associate Director, Merit Systems Accountability and Compliance

MARK LAMBERT
Digitally signed by MARK LAMBERT
Date: 2022.09.15 11:50:39 -04'00'

Subject: OPM's Response to Draft Dara Brief Evaluation of COVID-19's Impact on the Federal Employees Health Benefits (FEHB) Program Telehealth Services and Utilization, Request Number 2022-CAAG-0014 August 15, 2022

Thank you for the opportunity to respond to the Office of the Inspector General's (OIG) Draft Data Brief, Report Number 2022-CAAG-0014. The Draft Data Brief provides an OIG analysis of the FEHB Program utilization trends and program integrity risks in telehealth claims. The data brief shows a dramatic increase in the utilization of telehealth service in the FEHB Program since the beginning of the COVID-19 pandemic. Impacts of the pandemic have been felt in almost every segment of society and the FEHB Program is no exception. The COVID-19 pandemic brought particular attention to telehealth as a means of limiting exposure to other individuals while receiving medical care, thereby minimizing the risk of contracting or spreading the virus.

The Draft Data Brief contains five recommendations. Responses to your recommendations are provided below. Technical comments are included in Appendix A.

Federal Employees' Health Benefits Program (FEHB Program)

Recommendation 1:

Deleted By OIG – Not Relevant to the Final Report

Management Response: We do not concur.

OPM's response to the Notice of Finding and Recommendation (NFR) noted that we did not concur with the factual accuracy of this finding and that we did not concur with the recommendation. We continue to believe the data collected and reviewed by OIG is not complete, comprehensive, or representative of all FEHB Program Carriers as only 10 carriers were surveyed and only partial data for one carrier was reviewed. Nor do we believe the data is detailed enough to support any conclusion for a single carrier of the FEHB Program and can certainly not be extrapolated out to the entire Program.

The OIG states that most carriers do not have edits in place to check for impossible hours. We disagree with this statement as the questions used on which to base the conclusion were not clear. Additional clarification is needed from the surveyed carriers to arrive at a conclusion.

Carriers could have other controls in place to detect similar anomalies. Furthermore, the data we received from the OIG stated that six of ten carriers indicated they have edits for impossible hours, one indicated they did not have impossible hours edits, two carriers indicated they did not have any specific edits related to telehealth, and one carrier did not respond. It is our understanding that the OIG did not follow up with the carrier who did not respond, nor did it follow up with the two carriers that stated they did not differentiate telehealth claims. The OIG is concluding those carriers do not have impossible hours edits. Based on the data, we disagree with the conclusion that "most" carriers do not have the impossible hours edit, for either their in-person or telehealth claims. Thus, of the responses that are completely developed it appears that 6 of 7 carriers have impossible hour edits, or 86% of the carriers surveyed do have impossible hours edits.

We disagree with OIG's statement in evaluating Carriers' responses to Question 13. The OIG states, "While carriers do typically have system edits in place for duplicate payment identification, medical necessity reviews, upcoding, and coordination of benefits, the results of our telehealth carrier survey revealed that some carriers have waived some of these edits for telehealth claims." Those Carriers that state they do not use specific telehealth edits, have other controls in place. We also disagree with the use of the term "waived" since those carriers noted they have other controls.

We also cannot agree with the statement, "An analysis of OPM OIG's claims data warehouse identified a variety of patterns that could indicate potential fraud that was not caught by system edits." Despite finding patterns that could indicate potential fraud, the OIG has responsibilities to investigate fraud, waste, and abuse; it does not appear that the OIG found evidence that there is

potential fraud from the carriers' data. FEHB Carriers are required to have a robust fraud, waste, and abuse (FWA) program per Carrier Letter 2017-13 and Section 1.9 of the FEHB contracts. Carriers are required to review telehealth claims as part of their FWA program.

Further investigation would be needed to conclude that there is potential fraud and the OIG instructed OPM to not reach out to the carrier. We welcome additional engagement with the OIG if these claims result in any fraud. Furthermore, the claims data evaluated from one carrier does not lend itself to an application to all FEHB Carriers.

Recommendation 2:

Deleted By OIG – Not Relevant to the Final Report

Management Response: We do not concur

OPM's response to the Notice of Finding and Recommendation (NFR) noted that we did not concur with the factual accuracy of this finding and that we did not concur with the recommendation. We continue to believe the data collected and reviewed by OIG is not complete, comprehensive, or representative of all FEHB Program Carriers as only 10 carriers were surveyed. Nor do we believe the data is detailed enough to support any conclusion for a single carrier, much less the entire FEHB Program.

OPM does not agree with OIG's conclusion that there is a lack of restrictions or review placed on telehealth claims in the FEHB Program. Most carriers the OIG surveyed have specific telehealth edits in place and all carriers are required to have system edits in place to prevent erroneous payments. OPM requires carriers to adjudicate claims based on clinical appropriateness, medical necessity, and prudent business practices. We disagree with OIG's statement that our review of claims based on clinical appropriateness does not seem to currently be preventing claim payments for services inappropriately billed as telehealth since the OIG did not review the claims on clinical appropriateness. The OIG acknowledged that further analysis is needed for the claims they found during their evaluation to be conclusive for fraud.

The OIG indicates that the varied responses across carriers is due to the lack of specific guidance from OPM regarding procedures that could realistically be performed via telehealth. The right to practice medicine is a privilege granted by states. Each state has laws and regulations that govern the practice of medicine and specify the responsibilities of the medical board in regulating that practice. State medical boards establish the standards for their respective states including with regard to telehealth services.

Between Medicaid and private insurance, over three-quarters of Americans purchase health insurance regulated at the state level. State telehealth laws frequently note that no two states have the same regulations when it comes to coverage and payment.[13] States range from having no telehealth parity laws that specify which telehealth services are covered and their reimbursement rate, to having full coverage and payment parity for telehealth services.[14] Most states have similar telehealth rules for Medicaid and private payers but there are some exceptions. For instance, private insurance can generally reimburse for telehealth when the patient is at work or at home, while several states' Medicaid guidelines specify that care must be delivered in a qualified health-care facility to be reimbursed. While the federal government can promote telehealth coverage in the population it serves by changing rules for Medicare and by setting minimum coverage standards for Medicaid, state insurance regulators, Medicaid agencies, and medical boards can all changes rules for practice, coverage, and reimbursement for the use of telehealth services for those not insured through federal programs. OPM is not a direct provider or payor of health care services. The Federal Employees Health Benefits Act, 5 U.S.C. §8901 et seq., authorizes OPM to enter into contracts with private insurance carriers to administer and insure benefit plans. Therefore, a list such as that established by CMS, would not be appropriate in the context of FEHB since private insurance is controlled by state laws. Further, OPM does not regulate the practice of medicine. FEHB Program members receive medical services from providers that are bound by state provider regulations. A list of telehealth-eligible services for program members would need to be on a state-by-state basis, which state regulators and medical boards have implemented.

The OIG references CMS's list of Medicare-covered services that can be received through telehealth and notes that OPM does not have such a list. The OIG concludes that OPM's lack of a specific list of covered services "may put FEHBP members and the FEHBP itself at risk of overpaying for telehealth services due to suspicious billing practices, such as billing for services not rendered, upcoding, or impossible day scenarios." For the reasons we've previously stated, we do not agree with this conclusion.

Recommendation 3:

Deleted By OIG – Not Relevant to the Final Report

Management Response: We do not concur.

OPM's response to the Notice of Finding and Recommendation (NFR) noted that we did not concur with the factual accuracy of this finding and that we did not concur with the recommendation. We continue to believe the data collected and reviewed by OIG is not complete, comprehensive, or representative of all FEHB Program Carriers as only 10 carriers were surveyed. Nor do we believe the data is detailed enough to support any conclusion for a

[13] "State Telehealth Laws & Reimbursement Policies." Center for Connected Health Policy, Spring 2019. http://www.cchcpa.or/sites/default/files/2019-05/cchp_report_MASTER_spring_2019_FINAL.pdf

[14] "Telehealth Private Payer Laws: Impact and Issues." Center for Connected Health Policy, Spring 2017. http://www.milbank.org/wp-content/uploads/2017/08/MMF-Telehealth-Report-FINAL.pdf

single carrier or the entire FEHB Program.

The OIG states, "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 abiding by relevant requirements." It is unclear how the OIG can draw its conclusion as the carrier survey does not ask carriers to list or provide examples.

The OIG states, "there are very few controls in place to protect the confidentiality, integrity, and availability of the technologies used for telehealth sessions." We disagree with this statement. HIPAA, other Federal laws, and state laws that apply to providers would apply regardless of whether the benefit is being provided in-person or via telehealth. State laws may have additional restrictions on telehealth services that do not exist for in-person services. To our knowledge, the OIG has not completed an analysis of what statutory and regulatory framework already applies and does not have a basis to conclude that requirements already in place are not adequate.

Providers must comply with all applicable laws and regulations.

Further, the OIG states that they have expressed to OPM multiple times that their concern is that if the pandemic does continue, OPM should require FEHB Carriers to ensure more secure telehealth platforms to protect the privacy and security of our members. The Notification of Enforcement Discretion for Telehealth Remote Communications during the COVID-19 Nationwide Public Health Emergency was issued by the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS). OCR is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability act of 1996 (HIPPA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act to protect the privacy and security of protected health information. This notice allowed health care providers to use widely available communications software without fear of violating HIPAA, even if the software does not meet the HIPAA privacy and security requirements.

The OIG did not indicate that it considered OCR's discretion when issuing this recommendation. According to the "Frequently Asked Questions on Telehealth and HIPPA During the Public Health Emergency," OCR states that they believe many current and commonly available remote electronic communication products include security features to protect electronic protected health information (ePHI) transmitted between health care providers and patients. In addition, OCR believes that video communication vendors familiar with the requirements of the Security Rule often include stronger security capabilities to prevent data interception and provide assurances they will protect ePHI by signing a HIPAA business associate agreement (BAA).

Providers seeking to use video communication products are encouraged to use such vendors but will not be penalized for using less secure products in their effort to provide the most timely and accessible care possible to patients during the Public Health Emergency. Further the Notice states that providers are encouraged to notify patients that these third-party applications

potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.

OCR also took into account the remote communication product. They are saying "non-public facing" remote communication products can be used. Non-public facing remote communication products include, for example, Apple FaceTime, Facebook Messenger video chat, Google Hangout video, Whatsapp Videochat, Zoom, or Skype. Typically, these platforms employ end-to-end encryption which only allows an individual and the person with whom the individual is communicating to see what is transmitted. The platforms also support individual user accounts, logins, and passcodes to help limit access and verify participants. In addition, participants are able to assert some degree of control over particular capabilities, such as choosing to record or not record the communication or to mute or turn off the video or audio signal at any point. The OIG did not take into account the current security of the platforms used or the OCR's discretion when analyzing the technology requirements.

In its report, the OIG states, "As such, FEHBP providers have been held to no specific telehealth privacy and security requirements for over two years." In making this statement, the OIG discounts HHS's guidance, does not acknowledge that a national emergency continues and that many local providers may not have the technical abilities needed to meet HIPAA requirements. This could result in members not receiving care, arguably a far greatest risk, with potentially grave consequences than any discussed in this Draft Data Brief. FEHB Carriers have no control over out of network, non-contracted providers. Further, once the current COVID-19 public health emergency declaration ends, the Consolidated Appropriations Act of 2022 has ensured a 151-day extension period for many of the policies outlined in the COVID-19 public health emergency declaration to allow for a transition period. This includes telehealth platforms. In addition, ongoing efforts to expand telehealth beyond the pandemic persist in pending bills such as the Telehealth Extension Act, Cures 2.0 Act and Protecting Rural Telehealth Access Act, all of which seek to make existing telehealth flexibilities permanent. Concerning the modality of telehealth, the federal government has introduced a bill to standardize telehealth modality options such as Ensuring Parity in MA and PACE for Audit-Only Telehealth Act of 2021 or the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021. During this transition phase OPM believes it should wait to determine what the federal and state laws initiate on telehealth technology. If OPM issued guidance that opposes HHS's requirements, it could result in a lack of continuity of care and would be a barrier to FEHB members receiving health care during a time when provider offices were not seeing patients in-person. Furthermore, the OIG is inviting confusion among carriers if they are asked to follow multiple sets of standards issued by the Federal government.

Recommendation 4:

Deleted By OIG – Not Relevant to the Final Report

Management Response: We do not concur.

OPM's response to the Notice of Finding and Recommendation (NFR) noted that we did not concur with the factual accuracy of this finding and that we did not concur with the recommendation. We continue to believe the data collected and reviewed by OIG is not complete, comprehensive, or representative of all FEHB Program Carriers as only 10 carriers were surveyed. Nor is it detailed enough to support any conclusion for a single carrier or the entire FEHB Program.

We disagree with OIG's statement that they "found that some carriers had no controls over recording audio or video during telehealth visits." As a result, we disagree with the premise of the OIG's findings. Providers are subject to the laws of the state in which they practice.

Telehealth is an enforcement priority for federal and state enforcement agencies, including the US Department of Justice. Please refer to the Center for Connected Health Policy's (CCHP) Spring 2022 analyses and summary of telehealth policies to distinguish the states differences between telehealth policies. (https://www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-spring-2022/). Furthermore, the Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."

In its response to our comments on the OIG's NFR, OIG states that "given that telehealth sessions occur via technology rather than in person, the member and the provider may not necessarily know in which state the other is located." State laws mandate that the provider may only offer services in certain states. During the pandemic, almost every U.S. State and territory modified their requirements for telehealth in response to COVID-19. Again, some of these providers, depending on state, will continue to provide these services. OPM cannot issue specific guidance that would fit all FEHB Program carriers. It would cause additional and unnecessary confusion for a provider to administer a different standard depending on whether the member was in the FEHB Program or a different health group.

As noted above, we have several concerns with the recommendation: it discounts HHS and HIPAA guidance and does not acknowledge that a national emergency continues. The OIG is inviting confusion among carriers were they to be asked to follow multiple sets of standards issued by the Federal government. It would be especially inappropriate to issue guidance in opposition to HHS guidance as recommended by the OIG during the ongoing national emergency.

Recommendation 5:

Deleted By OIG – Not Relevant to the Final Report

Management Response: We do not concur.

OPM's response to the Notice of Finding and Recommendation (NFR) noted that we did not concur with the factual accuracy of this finding and that we did not concur with the recommendation. We continue to believe the data collected and reviewed by OIG is not complete, comprehensive, or representative of all FEHB Program Carriers as only 10 carriers were surveyed. Nor is it detailed enough to support any conclusion for a single carrier or the FEHB Program.

We disagree with OIG's conclusions. Telehealth is not a new benefit. We have not identified any unique risks associated with telehealth that would require specific guidance. HIPAA enforcement takes place on both the federal government, through HHS, and state government level. OPM does not have authority to change or add rules that conflict with HIPAA guidelines. The states issue telehealth billing, privacy, and security guidelines associated with the carriers. The Federal Employees Health Benefits Act, 5 U.S.C. §8901 et seq., authorizes OPM to enter into contracts with private insurance carriers to administer benefit plans.

OPM is fully committed to positioning the FEHB Program to help members combat COVID-19 and assist medically underserved populations, including elderly and residents in rural and urban areas who are not sufficiently connected to quality primary and secondary care, receive information and access to treatments as they become available.

Deleted By OIG – Not Relevant to the Final Report

Appendix A: Technical Comments

Definitions

Please use FEBHAR definitions were applicable.

Carrier or Health Insurance Carrier: means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan.

Community-Rated Health Maintenance Organization: Community-rating is defined per FEHBAR 48 CFR 1602.170-2.

Cost Sharing: is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Experience-Rated Fee for Service

Experience-Rated Health Maintenance Organization Experience-rating is defined in FEHBAR 48 CFR 1602.170-7.

Health Savings Account (HSA) (FEHB) - a tax-exempt trust or custodial account you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you incur. (IRS Publication 969 (2021)

High Deductible Health Plan (HDHP) - An HDHP is a health plan that satisfies certain requirements with respect to minimum deductibles and maximum out-of-pocket expenses. (IRS Notice 2019-45)

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