

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**HOME HEALTH AGENCIES RARELY
FURNISHED SERVICES VIA TELEHEALTH
EARLY IN THE COVID-19 PUBLIC
HEALTH EMERGENCY**

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September 2023
A-05-21-00026

Office of Inspector General

<https://oig.hhs.gov>

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Report in Brief

Date: September 2023
Report No. A-05-21-00026

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

In response to the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) expanded telehealth benefits to limit community spread and keep vulnerable patients in their homes while maintaining access to care. In April 2020, CMS revised Medicare regulations on an interim basis to retroactively allow home health agencies (HHAs) to use telehealth services beginning March 1, 2020. In November 2020, CMS finalized changes to those regulations to permanently allow home health services to be furnished via telehealth. While Medicare makes payments for some types of telehealth services, the final regulations prohibit payments for home health services furnished via telehealth. At the start of our audit, CMS did not require HHAs to report telehealth services on Medicare claims. Therefore, oversight agencies lacked the ability to effectively identify and monitor those services.

Our objective was to determine whether home health services furnished via telehealth early in the COVID-19 PHE were provided and billed in accordance with Medicare requirements.

How OIG Did This Audit

We selected a stratified random sample of 200 home health claims with beginning service dates from March 1 through December 31, 2020. We reviewed medical records to evaluate compliance with Medicare regulations for providing and billing telehealth services.

Home Health Agencies Rarely Furnished Services Via Telehealth Early in the COVID-19 Public Health Emergency

What OIG Found

HHAs rarely furnished services via telehealth early in the COVID-19 PHE; however, for the few claims in our sample with services furnished via telehealth, HHAs did not fully comply with Medicare requirements for providing them. Of the 200 sampled claims, 4 claims had home health services furnished via telehealth, so we estimate that there are 127,999 claims in the sampling frame with such services. None of the four claims fully complied with Medicare requirements for home health services furnished via telehealth. The errors occurred because the HHAs were unfamiliar with the Medicare requirements for such services, which were new early in the COVID-19 PHE. Of the remaining 196 sampled claims, 194 claims did not have home health services furnished via telehealth. For the remaining two sampled claims, we were unable to obtain medical records, so we could not determine whether home health services were furnished via telehealth.

Beginning July 1, 2023, CMS now requires HHAs to report the use of telehealth services on home health claims. CMS has instructed HHAs to use one of two G-codes to report the services on claims and to list each service as a separate, dated line item. CMS stated that such reporting will allow it to analyze the characteristics of patients utilizing telehealth and give it a broader understanding of the determinants that affect who benefits most from those services. Furthermore, in their March 2022 Report to the Congress, the Medicare Payment Advisory Commission recommended tracking the use of telehealth on home health claims to improve payment accuracy.

What OIG Recommends and CMS Comments

We recommend that CMS monitor HHA reporting of the new G-codes to determine whether further updates to regulations or guidance are necessary.

CMS concurred with our recommendation and provided information on the actions that it has taken and plans to take to address the recommendation.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Audit	1
Objective	1
Background	1
The Medicare Program and Payments for Home Health Services	1
Medicare Coverage for Home Health Services	1
Medicare Requirements for Home Health Services Furnished via Telehealth.....	2
How We Conducted This Audit	2
FINDINGS.....	3
New Guidance on Documenting Telehealth Services on Home Health Claims.....	4
RECOMMENDATION	4
CMS COMMENTS	4
OTHER MATTERS.....	5
APPENDICES	
A: Audit Scope and Methodology	6
B: Statistical Sampling Methodology	8
C: Sample Results and Estimate.....	10
D: CMS Comments	11

INTRODUCTION

WHY WE DID THIS AUDIT

In response to the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) expanded telehealth benefits to limit community spread of the virus and keep vulnerable patients in their homes while maintaining access to care. In April 2020, CMS revised Medicare regulations on an interim basis to retroactively allow home health agencies (HHAs) to use telehealth services beginning March 1, 2020. In November 2020, CMS finalized changes to those regulations to permanently allow home health services to be furnished via telehealth. The final regulations have new requirements regarding documenting such services and also prohibit payments for home health services furnished via telehealth. At the start of our audit, CMS did not require HHAs to report telehealth services on Medicare claims. Therefore, oversight agencies lacked the ability to effectively identify and monitor those services.

OBJECTIVE

The objective of our audit was to determine whether home health services furnished via telehealth early in the COVID-19 PHE were provided and billed in accordance with Medicare requirements.

BACKGROUND

The Medicare Program and Payments for Home Health Services

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS administers the program. Medicare Parts A and B cover eligible home health services under a prospective payment system (PPS). The PPS covers part-time or intermittent skilled nursing care and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. Under the home health PPS, CMS pays HHAs for each 30-day billing period of home health care that an eligible patient receives. CMS contracts with four Medicare administrative contractors (MACs) to process and pay claims submitted by HHAs. MACs are also responsible for conducting reviews of home health claims to ensure compliance with Medicare requirements.

Medicare Coverage for Home Health Services

Medicare covers home health services for eligible patients who are homebound and in need of skilled services. A physician or allowed nonphysician practitioner (NPP) must conduct a face-to-face visit to evaluate the patient's current condition and determine eligibility for home health services. To initiate home health care, a physician or NPP must send the HHA a verbal or written order for it. Within 5 days after the start of home health care, Medicare requires the

HHA to perform a comprehensive assessment that accurately reflects the patient's current health status and medical needs. The HHA, in conjunction with the physician or NPP, uses the results from the comprehensive assessment and the patient's medical history to develop the home health plan of care. The plan of care outlines, among other things, the services to be provided, the amount and frequency of visits, and the predicted outcomes of treatment.

Medicare Requirements for Home Health Services Furnished via Telehealth

Home health services are typically furnished by HHAs via in-person home visits, but some may now be furnished via telehealth. In April 2020, CMS revised Medicare regulations on an interim basis to retroactively allow HHAs to use telehealth services beginning March 1, 2020.¹ In November 2020, CMS finalized changes to those regulations to permanently allow home health services to be furnished via telehealth. The final regulations have new requirements regarding documenting such services and prohibit payments for them, including:²

- The plan of care must include any provision of telehealth services.
- The plan of care must describe how the use of telehealth services is tied to patient-specific needs identified in the comprehensive assessment.
- Telehealth services cannot substitute for a home visit ordered as part of the plan of care.
- Telehealth services cannot be considered a home visit for the purposes of patient eligibility or payment.

HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicare claims for home health episodes with services furnished via telehealth and beginning service dates from March 1 through December 31, 2020. During the audit period, CMS did not require HHAs to report telehealth services on Medicare claims. Therefore, we could not determine from the claim data whether the home health episodes included services furnished via telehealth. As a result, our sampling frame included Medicare claims for home health episodes without services furnished via telehealth.

The sampling frame consisted of approximately 7 million home health claims with \$12.4 billion in Medicare payments. From this sampling frame, we selected a stratified random sample of 200 claims with payments totaling \$365,419. We contacted HHAs to obtain medical records for each of the 200 sampled claims. We reviewed the medical records we received to determine whether home health services were furnished via telehealth and estimated the number of

¹ 85 Fed. Reg. 19230 (April 6, 2020) and 42 CFR § 409.43(a).

² 85 Fed. Reg. 70298 (November 4, 2020) and 42 CFR § 409.43(a)(3)(i)(B).

claims with such services in our sampling frame. We also determined whether home health services that were furnished via telehealth complied with Medicare requirements for providing them.

Some of the sampled claims without home health services furnished via telehealth had language in their plans of care that provided the option to use such services. We discuss the results of our review of such language in the Other Matters section of this report.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our scope and methodology, Appendix B describes our statistical sampling methodology, and Appendix C contains our sample results and estimate.

FINDINGS

HHAs rarely furnished services via telehealth early in the COVID-19 PHE; however, for the few claims in our sample with services furnished via telehealth, HHAs did not fully comply with Medicare requirements for providing them. Of the 200 sampled claims, 4 claims had home health services furnished via telehealth, so we estimate that there are 127,999 claims in the sampling frame with such services.³ None of the four claims fully complied with Medicare requirements for home health services furnished via telehealth. The errors occurred because the HHAs were unfamiliar with the Medicare requirements for such services, which were new early in the COVID-19 PHE. Of the remaining 196 sampled claims, 194 claims did not have home health services furnished via telehealth. For the remaining two sampled claims, we were unable to obtain medical records,⁴ so we could not determine whether home health services were furnished via telehealth.

None of the four sampled claims with home health services furnished via telehealth fully complied with Medicare requirements for such services. Of these four sampled claims, two did not include a provision in the plan of care allowing for the use of telehealth services. The remaining two claims had provisions in their plans of care allowing for the use of telehealth services, but the plans of care did not tie the use of telehealth services to patient-specific needs identified in the comprehensive assessment. In addition, for one of the remaining two claims, telehealth services substituted for a home visit ordered in the plan of care. These errors did not

³ The 90-percent confidence interval for the number of claims in the sampling frame with home health services furnished via telehealth was 16,018 to 239,980.

⁴ We were unable to contact the HHAs because they were no longer in business.

result in overpayments. The errors occurred because the HHAs were unfamiliar with the Medicare requirements for such services, which were new early in the COVID-19 PHE.

New Guidance on Documenting Telehealth Services on Home Health Claims

In its 2023 Home Health PPS Final Rule,⁵ CMS required HHAs to report the use of telehealth services on home health claims beginning July 1, 2023.⁶ CMS has instructed HHAs to report the services on claims as separate, dated line items and to do so using one of the following two G-codes:

- G0320: Home health services furnished using synchronous telemedicine rendered via a real-time, two-way audio and video telecommunications system.
- G0321: Home health services furnished using synchronous telemedicine rendered via telephone or other real-time, interactive, audio-only telecommunications system.

CMS indicated that requiring HHAs to report those codes will help it understand HHA use of telehealth. For example, CMS stated that such reporting will allow it to analyze the characteristics of patients utilizing telehealth and give it a broader understanding of the determinants that affect who benefits most from those services. Furthermore, in its March 2022 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) recommended tracking the use of telehealth on home health claims to improve payment accuracy.⁷

RECOMMENDATION

We recommend that CMS monitor HHA reporting of the new G-codes to determine whether further updates to regulations or guidance are necessary.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendation and provided information on actions that it had taken or planned to take to address our recommendations. CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix D.

⁵ 87 Fed. Reg. 66790 (November 4, 2022).

⁶ In this report, we use the terms “telemedicine” and “telehealth” interchangeably.

⁷ MedPAC, *March 2022 Report to the Congress: Medicare Payment Policy, Chapter 8: Home Health Care Services*.

OTHER MATTERS

During our review of medical records for the 194 sampled claims without home health services furnished via telehealth, we found that 60 records had plans of care that included language allowing for such services. We reviewed that language and determined that 58 of the 60 plans of care did not meet Medicare requirements. In all 58 plans of care, the use of telehealth services was not tied to patient-specific needs identified in the comprehensive assessment. In 16 of the 58 plans of care, the language suggested the use of telehealth services as a substitute for a home visit. Some plans of care had more than one type of error, and some language was duplicated in other plans of care. We shared the following examples⁸ with CMS personnel, and they agreed that such language did not meet Medicare requirements:

- “May use telehealth and telecommunications to provide services **as necessary and appropriate according to the patient’s condition** and in accordance with the plan of care.” This language was duplicated in 12 plans of care and does not tie the use of telehealth services to patient-specific needs identified in the comprehensive assessment.
- “All disciplines (except home health aide) may provide telehealth phone/remote/virtual visits **in lieu of an in-person visit** that does not require hands on or in-person assessment when an in-person visit is not possible due to the public health emergency related to the COVID-19 pandemic.” This language was duplicated in 12 plans of care and suggested the use of telehealth services as a substitute for a home visit.

The errors in language occurred because at the time the plans of care were written, furnishing home health services via telehealth was only recently allowed. HHAs reported dealing with many regulatory changes from the PHE and thinking that the language met requirements.

⁸ We shared a total of six examples of language in error with CMS personnel, and they agreed with our assessments. We include only the most duplicated example for each type of error.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicare claims for home health episodes with services furnished via telehealth and beginning service dates from March 1 through December 31, 2020. The sampling frame consisted of approximately 7 million home health claims with \$12.4 billion in Medicare payments. From this sampling frame, we selected a stratified random sample of 200 claims with payments totaling \$365,419. For each sampled claim with home health services furnished via telehealth, we evaluated compliance with requirements in 42 CFR § 409.43(a)(3)(i)(B).

We assessed CMS's internal controls and compliance with laws and regulations necessary to satisfy the audit objective. Specifically, our review of internal controls focused on CMS's oversight of how home health services furnished via telehealth were provided and billed. We assessed whether CMS implemented control activities through its policies and guidance. Our internal control review may not have identified all internal control deficiencies that may have existed at the time of this audit.

To assess the reliability of the data obtained from CMS's National Claims History file, we (1) performed electronic testing for obvious errors in accuracy and completeness, (2) reviewed existing information about the data and the system that produced them, and (3) traced a stratified random sample of 200 home health claims to source documents. We determined that the data were sufficiently reliable for the purposes of this report.

We conducted our audit from June 2021 through June 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal requirements related to home health services furnished via telehealth,
- communicated with CMS officials to gain a better understanding of its policies and guidance concerning Federal requirements for home health services furnished via telehealth,
- extracted Medicare home health claim data for the audit period from the National Claims History file,
- created a sampling frame of 6,969,435 claims totaling \$12,367,409,010,
- selected a stratified random sample of 200 claims for detailed review (Appendix B),

- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been canceled or adjusted,
- obtained billing and medical record documentation from HHAs to support the sampled claims,
- reviewed that documentation to determine whether home health services were furnished via telehealth and whether such services complied with Medicare requirements for providing them,
- used the results of the sample to estimate the number of claims with home health services furnished via telehealth in our sampling frame (Appendix C), and
- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 6,969,435 Medicare home health claims totaling \$12,367,409,010 and with beginning service dates from March 1 through December 31, 2020. The sampling frame contained only final home health claims⁹ that had payments greater than \$0, had Medicare as the primary payer, were not submitted by an HHA under investigation, and had not been previously reviewed by us or CMS contractors. During the audit period, CMS did not require HHAs to report telehealth services on Medicare claims, so we could not identify claims for home health episodes with services furnished via telehealth. Therefore, our sampling frame included Medicare claims for home health episodes without services furnished via telehealth.

SAMPLE UNIT

The sample unit was a Medicare home health claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing three strata based on the number of visits billed and outlier status. We selected 200 Medicare home health claims for review, as shown in Table 1.

Table 1: Frame Description and Sample Size

Stratum	Frame Information			Sample Size
	Claim Description	Number of Frame Units	Frame Dollar Value	
1	5 or fewer visits	2,912,486	\$3,765,751,855	75
2	6 or more visits with no outlier	3,722,510	7,677,555,743	95
3	6 or more visits with outlier	334,439	924,101,412	30
Total		6,969,435	\$12,367,409,010	200

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software.

⁹ We define final home health claims as those tied to payments in full, which do not include requests for anticipated payment. Specifically, we included only type-of-bill codes 327, 329, 32G, 32H, 32I, and 32M.

METHOD OF SELECTING SAMPLE UNITS

We sorted the items in each stratum by the Data Extract System View Receiving Link Number¹⁰ and then consecutively numbered the items in each stratum in the sampling frame. We generated the random numbers for our sample according to our sample design and then selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the number of claims with home health services furnished via telehealth in our sampling frame. We calculated the point estimate and the corresponding two-sided 90-percent confidence interval for this estimate.

¹⁰ This field contains a sequentially assigned number for the claims included in the file and allows the user to tie children line items to the parent claim.

APPENDIX C: SAMPLE RESULTS AND ESTIMATE

Table 2: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Sample Items With Telehealth
1	2,912,486	\$3,765,751,855	75	\$104,515	2
2	3,722,510	7,677,555,743	95	186,792	1
3	334,439	924,101,412	30	74,112	1
Total	6,969,435	\$12,367,409,010	200	\$365,419	4

**Table 3: Estimated Number of Claims With Home Health Services
Furnished via Telehealth in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)**

Point estimate	127,999
Lower limit	16,018
Upper limit	239,980

APPENDIX D: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

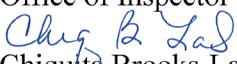
Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: September 15, 2023

TO: Amy J. Frontz
Deputy Inspector General for Audit Services
Office of Inspector General

FROM: 
Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Home Health Agencies Rarely
Furnished Services Via Telehealth Early in the COVID-19 Public Health
Emergency (A-05-21-00026)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

Sections 1895(e)(1)(A) and (B) of the Social Security Act specify that telecommunications services cannot substitute for in-person home health services ordered as part of the plan of care certified by a physician and are not considered a home health visit for purposes of eligibility or payment under Medicare. However, even prior to the COVID-19 Public Health Emergency (PHE), CMS acknowledged the importance of technology in allowing home health agencies the flexibility of furnishing services remotely.

As such, in the Calendar Year (CY) 2019 Home Health (HH) Prospective Payment System (PPS) final rule with comment period (83 FR 56406), for purposes of the Medicare home health benefit, CMS recognized "remote patient monitoring" as a telecommunications technology that was allowable as an administrative cost in CMS regulations at 42 CFR § 409.46(e). The regulation defined such monitoring as the collection of physiologic data (for example, electrocardiogram (ECG), blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the home health agency.¹ In the CY 2019 HH PPS final rule with comment period, CMS also finalized in regulation at § 409.46(e) that the costs of remote patient monitoring would be considered allowable if it was used by the home health agency to augment the care planning process (83 FR 56527). Since the declaration of the COVID-19 PHE in early 2020, the use of telecommunications technology has become more prominent in the delivery of healthcare in the United States. Based on anecdotal evidence, CMS determined that many beneficiaries preferred to stay home than go to physician's offices and outpatient centers to

¹ Medicare and Medicaid Programs; Calendar Year 2019 Home Health Prospective Payment System Rate Update and Calendar Year 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements and Training Requirements for Surveyors of National Accrediting Organizations; Final Rule with comment period (83 FR 56406)(11/13/2018). Accessed at: <https://www.govinfo.gov/content/pkg/FR-2018-11-13/pdf/2018-24145.pdf>

seek care. Telecommunications also reduced the number and frequency of care providers furnishing services inside patient homes, to avoid exposure to COVID-19. Accordingly, CMS implemented additional policies under the HH PPS to make providing and receiving services via telecommunications technology easier.² These policies were made permanent to include the provision of home health services via telecommunications technology beyond the COVID-19 PHE as long as such services are included on the home health plan of care though such services cannot substitute for a home visit ordered as part of the plan of care and cannot be considered a home visit for the purposes of patient eligibility or payment. However, such policies did not require reporting home health services furnished via telecommunications technology on home health claims. However, CMS has continued to receive anecdotal reports that home health agencies are using telecommunications technology to furnish services to Medicare beneficiaries.

To collect more complete data on the use of telecommunications technology in the provision of home health services, CMS began requiring the reporting of such data on home health claims (87 FR 66859), beginning in July of 2023. Data are now collected through the use of three new G-codes identifying when home health services are furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system.

CMS recognizes the importance of continuing to provide Medicare beneficiaries with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and post-payment reviews. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

Additionally, CMS has taken action to reduce improper Medicare payments by educating health care providers on proper billing. CMS educates health care providers on Medicare billing through various channels including the Medicare Learning Network (MLN), weekly electronic newsletters, and quarterly compliance newsletters. For example, in November 2022 CMS published a MLN Matters with information for home health providers regarding telehealth home health services and the new G-codes.³

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS monitor reporting of the new G-codes to determine whether further updates to regulations or guidance are necessary.

CMS Response

CMS concurs with this recommendation. In the CY 2023 HH PPS final rule (87 FR 66858) CMS stated that collecting data on the use of telecommunications technology on home health claims would allow us to analyze the characteristics of the beneficiaries utilizing services furnished

² Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Interim final rule with comment period (85 FR 19230) (4/6/2020). Accessed at <https://www.govinfo.gov/content/pkg/FR-2020-04-06/pdf/2020-06990.pdf>. Calendar Year 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements, and Home Infusion Therapy Services and Supplier Enrollment Requirements; and Home Health Value-Based Purchasing Model Data Submission Requirements; Final rule with comment period (85 FR 70298) (11/4/2020). Accessed at: <https://www.govinfo.gov/content/pkg/FR-2020-11-04/pdf/2020-24146.pdf>.

³MLN Matters – Telehealth Home Health Services: New G-Codes available at: <https://www.cms.gov/files/document/mm12805-telehealth-home-health-services-new-g-codes.pdf>

remotely and give us a broader understanding of the social determinants that affect who benefits most from these services, including what barriers may potentially exist for certain subsets of beneficiaries.⁴ CMS also stated that the analysis of the provision of home health services would assist us in understanding how such technology might be impacting the provision of care to certain beneficiaries; costs; quality; and outcomes, and determine if further requirements surrounding the use of telecommunications technology is needed.

⁴ Medicare Program; Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements; Final rule with comment period (87 FR 66790) (11/4/2022). Accessed at: <https://www.govinfo.gov/content/pkg/FR-2022-11-04/pdf/2022-23722.pdf>.