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TELEHEALTH, FRAUD AND COMPLEXITY: CONSIDERATIONS FOR POLICYMAKERS

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The COVID-19 pandemic [drastically shifted](#) how Americans accessed health care. Telehealth services became a main source of medical care, and as such, lawmakers, agencies and political leaders rushed to ensure that accessing telehealth was [relatively easy](#), with as few regulatory hurdles as possible. Now, as lawmakers grapple with which of these temporary changes to make permanent for the new telehealth landscape, some are concerned about the potential for fraud in telehealth.

This is understandable; in late 2020, as another wave of COVID-19 hit the United States, the U.S. Department of Justice [charged](#) over 80 medical professionals with nearly \$4.5 billion in telehealth-related fraud. The charges [allege](#) that providers made fraudulent insurance claims for, among other things, diagnostics after no or little audio interaction with patients and medical equipment charges. However, as the Alliance for Connected Care [notes](#), these charges were in relation to violations made prior to the changes in federal telehealth restrictions that the pandemic brought.

Advocates for telehealth maintain that the use of video consultations and audio-only phone calls can greatly contribute to greater health care access in the states, as long as proper procedures are in place to prevent fraud, reduce uncertainty and complexity, and ensure equitable access to these services. And while telehealth fraud is not to be dismissed, it is reasonable to think that any fraudulent activity during the surge in telehealth use due to the pandemic may have ultimately been short-term fraud opportunities rather than an opening of floodgates for systemic fraud going forward. Here, we suggest policy considerations for these issues:

Prevent telehealth fraud:

Egregious fraud in telehealth programs seems largely unfounded. However, legislators can establish a requirement that patients, not providers, initiate consultations. For example, pending Arizona legislation on telehealth addresses fraud in this way: [current bill language](#) requires that patients must initiate audio-only consultations. This ensures the appointment was sought out and not just an attempt to bill insurance. It is also likely this can be achieved by requiring providers obtain signatures from patients acknowledging they initiated the consultation. The Federal Trade Commission's Contact Lens Rule (CLR), for example, [already employs](#) this mechanism in a similar manner. The CLR maintains that providers must obtain patient signatures acknowledging the patient has received a copy of her prescription information unprompted. Establishing requirements that services are only billable if the patient initiates them may cut down on billing for frivolous or unnecessary consultations that practitioners initiate as a way to increase their billable visits.

Reduce uncertainty and complexity:

In April 2018, the Office of Inspector General (OIG) [issued a report](#) on telehealth spending in Medicare and incidences of improper Medicare telehealth billing for 2014-2015. Of the telehealth-related claims that were improperly billed, the OIG [maintained](#) that these were due to improper oversight from the Centers for Medicare and Medicaid Services (CMS), as well as confusion among practitioners over Medicare requirements. For example: telehealth services for Medicare beneficiaries prior to the pandemic were only allowed to occur in highly specific originating sites; one improper telehealth bill in this report came from an independent renal dialysis center, but only hospital-based renal dialysis centers qualified as originating sites for telehealth under Medicare. As such, simplifying telehealth requirements for Medicare would go a long way

in reducing confusion and improper billing. Telehealth expansion during the pandemic simplified requirements by allowing more locations to be considered originating sites. Making these changes permanent, and working to educate practitioners about these changes, can help reduce improper billing.

Ensure equitable access:

Audio-only telehealth methods were **important** during the pandemic and will continue to be, especially for those without reliable internet access or smartphones with video capability. However, legislators considering **permanently expanding** reimbursement of audio-only telehealth methods must address the challenges. Audio-only methods are perhaps more prone to fraud (e.g., providers calling patients for unprompted “check-ins” and billing insurance, or providers previously unknown to patients calling for consultations) than video methods. However, requiring proof that a patient initiated a consultation would also apply to reducing fraud for audio-only methods, while still granting more equitable access to telehealth for more Americans.

CONCLUSION

The concerns over fraud in telehealth, especially with any major expansion of telehealth use, are understandable. However, it is likely that small policy tweaks can go a long way to prevent it. Policymakers can seek out solutions that prevent fraud with minimal changes like requiring patient-initiated consultations, reducing complexity and uncertainty around requirements to increase compliance, and still maintaining equitable access for all Americans.

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