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Agency of Human Services

BACKGROUND

Act 6 of 2021 requires health insurance plans, and Vermont Medicaid to the extent permitted by the Centers for Medicare and Medicaid Services, to provide coverage for all medically necessary, clinically appropriate health care services delivered by audio-only telephone to the same extent that the plan would cover the services if they were provided through in-person consultation.[1] Act 6 of 2021 specifically requires that services that are covered when provided in the home by home health agencies shall be included (if medically necessary and clinically appropriate).

The Department of Financial Regulation is required to determine the appropriate codes or modifiers, or both, to be used by providers and insurers, in the billing of and payment for health care services delivered using audio-only telephone to allow for consistent data collection. Finally, the Department of Financial Regulation is required to determine the amounts that health insurance plans shall reimburse health care providers for delivering health care services by audio-only telephone, with a reasonable balance between costs to patients and the health care system and reimbursement amounts that do not discourage providers from delivering medically necessary, clinically appropriate health care services by audio-only telephone.

AUDIO-ONLY COVERAGE AFTER THE PUBLIC HEALTH EMERGENCY ENDS: FINAL PROPOSED RECOMMENDATIONS

Determination of Appropriate Procedure Codes and Modifiers

Medicare's public health emergency response resulted in Medicare's issuance of a list of services payable when furnished via telehealth (defined by Medicare as real-time, interactive communication using, at minimum audio and video); the list of services indicates specific services that can be delivered by audio-only telephone and meet the service requirements.[2] During the public health emergency, these audio-only services could be billed to Medicare using modifier -95 (description: synchronous telemedicine service rendered via real-time, interactive audio and video). Rather than implement a modifier that would not be appropriate for use with audio-only outside of the public health emergency, Vermont Medicaid instead implemented a specific modifier (V3) to identify health care services furnished by audio-only telephone and billed through fee-for-service reimbursement during the COVID-19 public health emergency.

[1] https://legislature.vermont.gov/bill/status/2022/S.117
[2] https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

For the period after the COVID-19 public health emergency terminates, the Department of Vermont Health Access proposes that:

- Providers who are allowed to bill for evaluation and management services would continue (or begin) to submit claims with the telephonic evaluation and management service procedure codes (i.e., CPT 99441 – 99443) when medically necessary and clinically appropriate. This code set will be identifiable in the claims data as being delivered by audio-only telephone; the V3 modifier will **not** be required. DVHA will indicate the V3 modifier is "not allowed" for new/established patient office visits (i.e., evaluation and management service codes 99202 – 99215) effective termination of the COVID-19 public health emergency.

- Providers who are not allowed to bill for evaluation and management services would use newly available telephonic assessment and management service procedure codes when medically necessary and clinically appropriate (i.e., CPT 98966 – 98968; DVHA will broaden the provider types who are allowed to submit claims with these codes to licensed mental health clinicians, occupational therapists, physical therapists, speech language pathologists, etc. consistent with Medicare's COVID-19 response). This code set will be identifiable in the claims data as being delivered by audio-only telephone; the V3 modifier will **not** be required.

- The telephonic evaluation and management service codes are the audio-only codes Medicare uses for evaluation and management services furnished by audio-only; this is an important consideration for when Medicare is the primary payer, and any crossover claims that Vermont Medicaid could receive. Additionally, coverage and reimbursement for these particular service codes was the approach employed by most state Medicaid programs in response to the Emergency (to provide coverage for audio-only evaluation and management services).

  Sample Code Description: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment (the specific code indicates time required for medical discussion).

- For all other medically necessary and clinically appropriate health care services identified on Medicare's List as meeting the code requirements when delivered through audio-only telephone and when covered by Vermont Medicaid, providers would submit claims for the procedure code with the V3 modifier to identify in the claims data that the service was delivered through audio-only telephone. It is our understanding that Medicare will continue to update the List of services that meet the requirements for audio-only delivery as more information becomes available regarding patient safety and quality of care; thus, Vermont Medicaid will need to monitor and update Vermont Medicaid's coverage in alignment with Medicare for Vermont Medicaid-covered services.

- This means that medically necessary, clinically appropriate, Medicaid-covered services provided by home health agencies that are currently submitted with revenue codes for billing purposes will need to be submitted with a HCPCS code and V3 modifier once the COVID-19 public health emergency terminates. This requirement will allow those services provided by home health agencies that are furnished through audio-only telephone to be identified in the claims data as being furnished through audio-only telephone. It appears that system modifications will be required within the Medicaid Management Information System; the extent of system modifications is being investigated currently by Department staff.

- It is important to note that Agency of Human Service departments administering specialized programs have the authority to establish and define audio-only telephone policies for the specialized programs managed by these departments when such policies are medically necessary and/or clinically appropriate.

AUDIO-ONLY REIMBURSEMENT AFTER THE PUBLIC HEALTH EMERGENCY ENDS: FINAL PROPOSED RECOMMENDATIONS

Determination of the Amounts that Health Insurance Plans Shall Reimburse Health Care Providers for Delivering Health Care Services by Audio-only Telephone.

Medicaid programs are required to provide access to comprehensive, cost-effective care. Medicare's system of determining the actual cost of providing services assigns relative value units to telephonic evaluation and management and telephonic assessment and management service codes. Outside of the COVID-19 public health emergency, this resulted in payment levels that were below those for in-person evaluation and management services based on clinical skill/time of the provider, expense to the practice, and cost of professional liability insurance indicating that audio-only services provide a cost-effective option for health care services for certain services that are clinically appropriate to be delivered by telephone.

Based on an analysis of Medicare's system for determining the actual cost of providing services, and for medically necessary and clinically appropriate Medicaid-covered services furnished through audio-only telephone, Vermont Medicaid will reimburse audio-only service delivery at 55% – 75% of the in-person reimbursement rate for the equivalent service.

Rationale for Appropriate Reimbursement: Based on Medicare's Resource-Based Relative Value Scale system for determining the cost of providing services, a comparison of Vermont Medicaid reimbursement rates indicates that the appropriate reimbursement rate for audio-only delivery should fall between 53.6% - 73.7% of the reimbursement rate determined for an in-person equivalent service.

Sample Comparison of Current Vermont Medicaid rates:
Telephonic E/M 99442 (11-20 minutes): $22.61

Established Patient 99212* (avg. 10 minutes): $37.59
Current: 60%

Telephonic E/M 99443 (21-30 minutes): $33.20
Established Patient 99213* (avg. 15 minutes): $61.95
Current: 53.6%
*CPT 99214 and 99215 are associated with moderate and high, respectively, severity of the presenting problem so these were not included as comparisons.

Telephonic A/M 98968 (21-30 minutes): $37.51
Psychotherapy, Individual, 90832 (30 minutes): $50.91 or $56.00 (dependent upon provider type)
Current: 73.7% or 66.9% (dependent upon provider type)

EMERGING RESEARCH: CLINICAL BENEFITS, PATIENT SAFETY, AND QUALITY OF CARE

As research is still emerging regarding demonstration of clinical benefits and concerns for patient safety and quality of care related to services delivered by an audio-only modality (i.e., beyond audio-only evaluation and management, assessment and management, and mental health services), the Department of Vermont Health Access recommends that Vermont Medicaid follow Medicare's determination of services that can be delivered by audio-only telephone and meet the service requirements.[3] Claims for Vermont Medicaid-covered services identified on the crosswalk to the Medicare Telehealth List for audio-only delivery would continue to be submitted to Vermont Medicaid with the specific modifier (V3) to identify that the service was delivered through audio-only telephone (note: the List will not contain the telephonic specific codes, e.g., 99441-99443, in order to make it clear that these codes do not require the V3 modifier). This is particularly important because Vermont Medicaid's State Plan specifies that the Department of Vermont Health Access is responsible for assuring access to medically necessary and clinically appropriate care, including monitoring and evaluating appropriateness, quality, and effectiveness of health care services requested for Vermont Medicaid members and correct coding must be adhered to outside of the circumstances of the public health emergency.

STATE PLAN AMENDMENT

States have discretion to select from a variety of codes and modifiers in order to identify, track, and reimburse for services delivered through telehealth and audio-only telephone; Vermont Medicaid will submit a state plan amendment to ensure the proposed approach for coverage and reimbursement of medically necessary, clinically appropriate health care services furnished through audio-only telephone is approved by the Centers for Medicare and Medicaid Services to ensure federal financial participation is not negatively impacted.

[3] https://www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part