

**STATE OF VERMONT
DEPARTMENT OF FINANCIAL REGULATION**

IN RE: CODING AND REIMBURSEMENT)
FOR AUDIO-ONLY TELEPHONE SERVICES)
REQUIRED BY ACT 6 OF 2021)
)
)

Docket No. 21-026-I

ORDER

WHEREAS, the Commissioner of the Department (the “Commissioner”) is responsible for administering and enforcing the insurance laws and regulations of the State of Vermont;

WHEREAS, Act 6 of 2021, Section 6, required the Department to work in consultation with the Department of Vermont Health Access (DVHA), the Green Mountain Care Board (GMCB), representatives of health care providers, health insurers, and other interested stakeholders to determine:

- (a) appropriate billing and payment codes or modifiers for audio-only telephone services;
- and
- (b) reimbursement rates for audio-only telephone services.

WHEREAS, the Department solicited and received proposals from interested parties, including the Department of Vermont Health Access (DVHA), Cigna, MVP Health Care, Blue Cross Blue Shield of Vermont, and the Coalition of Health Care Associations as to coding and reimbursement for audio-only telephone services.

WHEREAS, the Department has consulted with Department of Vermont Health Access (DVHA), and GMCB.

NOW THEREFORE, the Commissioner makes findings and ORDERS as follows:

FINDINGS OF FACT

1. The Department, through its Insurance Division, is charged with administering and enforcing the State of Vermont's insurance laws and regulations.
2. DVHA is responsible for administering the Vermont Medicaid health insurance program and Vermont's State-based exchange for health insurance, Vermont Health Connect.
3. GMCB is an independent five-member board responsible for, among other things, reviewing requests for health insurance premium rates in the large, small, and individual insurance markets plans and maintaining Vermont's all-payer claims database, the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), and hospital discharge database, the Vermont Uniform Hospital Discharge Data Set (VUHDDS).
4. On January 31, 2020, Secretary of Health and Human Services Alex M. Azar declared a public health emergency (PHE) for the entire United States to aid the nation's healthcare system in responding to COVID-19.
5. On March 13, 2020, Governor Phil Scott declared a state of emergency in Vermont to help ensure Vermont had all the necessary resources to respond to the COVID-19 PHE.
6. Under 8 V.S.A. § 4100k, commercial health insurance plans in Vermont are required to provide coverage for health care services and dental services delivered through telemedicine, defined as "interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996[(HIPAA),]" at the same reimbursement rate as the equivalent in-person service. This definition of telemedicine specifically excluded audio-only telephone.
7. Prior to the COVID-19 PHE, commercial health insurance plans were not required to provide coverage for health care services delivered through audio-only telephone.

8. Vermont Medicaid provides coverage for telemedicine, defined as two-way, real-time, audio and video interactive communication, through a secure connection that complies with HIPAA, when medically necessary, clinically appropriate for delivery through telemedicine and within the provider's licensed scope of practice. Covered services delivered through telemedicine are "reimbursed at the same rate as the service being provided in a face-to-face setting."

9. Prior to the COVID-19 PHE, audio-only interactions were not considered telemedicine and were not generally covered by Vermont Medicaid with exceptions for certain services, such as telephone evaluation and management services by physicians or other qualified health care professionals who may report evaluation and management services provided to an established patient.

10. Beginning in April 2020, the Department adopted a series of emergency rules to ensure safe access to health care during the COVID-19 PHE in a manner that would minimize the spread of the virus.

11. Among other things, early in the COVID-19 PHE, the Department required commercial health insurance plans in Vermont to provide coverage of health care services delivered through audio-only telephone, including telephone triage services, at the same reimbursement rate as for the equivalent in-person service. The Department's current emergency rule, Reg. H-2020-06-E, will remain in force until July 1, 2021.

12. On March 18, 2020, Vermont Medicaid implemented several changes to support Medicaid-participating providers in responding effectively to the COVID-19 PHE, including covering and reimbursing medically necessary, clinically appropriate Medicaid-covered services delivered by audio-only telephone at the same rate as Medicaid-covered services provided in-person.

13. On July 6, 2020, Governor Scott signed Act 140 of 2020, which required the Department to convene a working group to develop recommendations for commercial health insurance and Medicaid coverage of health care services delivered by telephone after the COVID-19 PHE has ended.

14. The working group convened by the Department eventually included over 80 members representing providers, health insurers, DVHA, GMCB, the Vermont Medical Society, Bi-State Primary Care Association, the VNAs of Vermont, the Vermont Association of Hospitals and Health Systems, Vermont Program for Quality in Health Care, and the Office of the Health Care Advocate.

15. In October 2020, the Department asked working group members for recommendations. Over a dozen working group members responded with recommendations reflecting their unique goals, points of view, and expertise relating to audio-only telephone and insurance coverage thereof.

16. On December 1, 2020, the working group delivered its report to the Legislature, recommending that commercial insurers continue coverage of audio-only telephone after the COVID-19 PHE utilizing value-based reimbursement where appropriate for provider type and size. The working group also found that transitioning to a permanent, value-based payment model was not practical with the data collected during the COVID-19 PHE and that implementation would likely require two years of data collection.

17. The working group did not reach consensus on whether audio-only health care services should be reimbursed at parity with in-person services or at some other rate.

18. On March 29, 2021, Governor Scott signed Act 6 of 2021, which added 8 V.S.A. § 4100l, requiring health insurance plans 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. Section 4100l allows insurers to charge an otherwise permissible deductible, co-payment, or coinsurance for a health care service delivered by audio-only telephone if it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

19. Act 6 requires the Department, working in consultation with other stakeholders, to set appropriate billing codes for health care services delivered by audio-only telephone and to conduct a two-year study of audio-only telephone utilization beginning in plan year 2022.

Vermont Medicaid is required to participate in the study to the extent permitted by the Centers for Medicare and Medicaid Services (CMS).

20. Act 6 further requires the Department, working in consultation with DVHA and the GMCB to determine reimbursement for audio-only telephone services. In doing so, the Department must “find a reasonable balance between the costs to patients and the health care system and reimbursement amounts that do not discourage health care providers from delivering medically necessary, clinically appropriate health care services by audio-only telephone.”

21. On April 2, 2021, The Department solicited proposals from interested parties as to coding and reimbursement for audio-only telephone services.

22. The Department received proposals from DVHA, Cigna, MVP Health Care, Blue Cross Blue Shield of Vermont, and the Coalition of Health Care Associations. All proposals are appended to this Order.

23. Coding of audio-only telephone services must utilize accepted Current Procedural Terminology (CPT) language and definitions.

24. Providers may code audio-only telephone services using the CPT code for in-person services with a modifier to allow the claims processing system to distinguish between services delivered by telephone and in-person services.
25. Providers may also code audio-only telephone services using telephone-only evaluation and management (E/M) codes, such as CPT 99441, 99442, and 99443, when use of such codes is required. Telephone-specific E/M codes do not require a modifier.
26. CMS maintains a list of services payable under the Medicare Physician Fee Schedule when furnished via telehealth, including services payable as audio-only interactions. This list is used by Vermont Medicaid to determine whether a service is clinically appropriate when provided by audio-only telephone.
27. 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.
28. Due to fixed costs, including rent, staffing, and other overhead, healthcare providers with a physical presence in Vermont commented that the short-term expenses associated with providing audio-only telephone services are generally comparable to in-person services.

ORDER

NOW, THEREFORE, based on the above Findings of Fact, the Commissioner ORDERS as follows:

1. Terms used herein have the meanings given to such terms, if any, in 8 V.S.A. § 4100l and 18 V.S.A. §§ 4601 and 9402.

2. Between July 1, 2021 and December 31, 2021, provisions of Regulation H-2020-06-E (Access to Health Care Services During the COVID-19 Pandemic) relating to coding and reimbursement shall continue: Health insurance plans shall provide the same reimbursement rate for services billed using equivalent procedure codes and modifiers, subject to the terms of the health insurance plan and provider contract, regardless of whether the service was provided through in-person consultation with a health care provider or through telemedicine or audio-only telephone.

3. Beginning on January 1, 2022:

a. Health insurance plans shall provide reimbursement for audio-only telephone services billed using accepted CPT language and definitions including both CPT codes for in-person services and telephone-specific E/M codes.

i. Audio-only telephone services using the CPT code for in-person services shall be reimbursable if the claim is submitted with a **V3 modifier** or any more specific, nationally-recognized successor modifier that may subsequently be adopted by the American Medical Association (to indicate “service delivered via telephone, i.e., audio-only”) and a place of service code of “**99 – other.**”

1. The V3 modifier should not be used with telephone-specific E/M codes.

2. Commercial health insurance plans may additionally reimburse audio-only telephone claims with a **V4** modifier to allow differential reimbursement.

ii. In determining which codes are clinically appropriate for audio-only delivery, commercial health insurance plans shall consider providers' clinical judgment, as documented in the medical record under Act 6. Commercial health insurance plans are also encouraged to align as closely as possible with codes identified by Vermont Medicaid as "telephone allowable." Nothing in this order, however, shall be construed to require commercial payers to reimburse Medicaid-specific codes.

b. Health insurance plans shall reimburse providers for audio-only services at a rate no less than 75% of the rate for equivalent in-person or audio/visual telemedicine covered service. Plans are strongly encouraged to negotiate rates with providers for audio-only telephone services that reflect their clinical value. Telephone-specific E/M codes with no in-person equivalent shall be reimbursed subject to the terms of the health insurance plan and provider contract.

4. This Order shall remain effect until December 31, 2022, or until rescinded or superseded by the Commissioner.

5. This Order shall be governed by and construed under the laws of the State of Vermont.

ENTERED at Montpelier, Vermont, this 29th day of June 2021.

/s/ Michael S. Pieciak

MICHAEL S. PIECIAK, Commissioner
Vermont Department of Financial Regulation

Appendix

Stakeholder Coding and Reimbursement Proposals



State of Vermont

Department of Vermont Health Access

[Phone] 802-879-5900

Office of the Commissioner

280 State Drive, NOB 1 South

Waterbury, VT 05671-1010

<http://dvha.vermont.gov>

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 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 does not contain the telephonic specific codes, e.g., 99441-99443). 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>

TO: E. Sebastian Arduengo, Assistant General Counsel
(Sebastian.arduengo@vermont.gov)

FROM: Lisa Fearon, Blue Cross and Blue Shield of Vermont
Sara Teachout, Blue Cross and Blue Shield of Vermont

SUBJECT: Coding and Reimbursement Proposal for Audio-Only Services under Act 6 of
2021 (S. 117)

DATE: April 30, 2021

Dear Sebastian:

Thank you for the opportunity to submit a proposal for coding and reimbursement for audio-only services. Services delivered by telephone, where clinically appropriate, are a valuable addition to the suite of health care options available to patients and providers, especially in the case of established patient-provider relationships. However, Blue Cross and Blue Shield of Vermont (Blue Cross) continues to have significant concerns about promoting audio-only care as a substitute for either audio-visual telemedicine or in-person care if those options are available to the patient and the provider. Additionally, payment levels should reflect the reduced value of the audio-only services as compared with audio-visual or in-person services.

Blue Cross's proposal for audio-only coding and reimbursement has two main components:

- Providers should bill using the CPT® code for in-person services but apply a modifier. The application of this modifier will allow the insurance claims system to distinguish between services delivered via telephone and those delivered by either audio-visual means or in person. The commercial insurance payment for these codes, when billed with the modifier, will be paid at a reduced rate, reflecting the lower value of, and lower cost to deliver, telephone-only services. Mental health/substance use disorder (MHSUD) providers will apply a V1 modifier and the services will pay at 80% of the in-person rate. Medical providers will apply a V2 modifier and the services will pay at 55% of the in-person rate.
- Providers may continue to utilize the telephone-only evaluation and management (E/M) codes (CPT® 99441, 99442, and 99443). There are circumstances, such as where a patient has Medicare as primary coverage, where the use of these codes is required for services delivered by telephone. The commercial insurance payment for CPT® 99442 should be aligned with the audio-only payment for CPT® 99212, and the payment for CPT® 99443 should be aligned with the audio-only payment for CPT® 99213.

Proposal

1. Use a Modifier for Clinically Appropriate Services Provided by Telephone

Table 1 reflects the list of codes that are clinically appropriate for delivery by telephone. This list is based on the Blue Cross temporary/emergency payment policy implemented during the public

health emergency for telephone only services, modified to remove some services that are best delivered via in-person visits or audio-visual means from a quality of care perspective. For these codes, the physician or other qualified health care professional must bill a modifier, and the commercial insurer will pay a reduced rate. Initial information suggests that MHSUD services may be effectively provided by telephone. As such, the reduction for MHSUD services is less than the reduction for medical services. MHSUD providers should bill with one modifier (V1), and medical providers should bill with a separate modifier (V2). The V1 modifier will take a 20% reduction to the current in-person rate, and the V2 modifier will take a 45% reduction to the current in-person rate.

Note that Table 1 includes only a handful of office visit E/M codes, specifically, CPT®s 99202, 99203, 99212, and 99213. The rationale for limiting to this subset of E/M codes is as follows:

- the timeframes specified in these code descriptions aligns with our understanding of the typical length of telephone-only visits; we assume that visits longer than the timeframes described in these codes should be delivered either via audio-visual telemedicine or delivered in person; and
- allowing codes for services provided to both new and established patients will allow for better data gathering (our assumption is that telephone-only services are most appropriate and most frequently utilized for established patients).

Table 1. Existing Codes that are not considered telephone-only

Code Type	Number	Description	Reimbursement
CPT®	90791	Psychiatric diagnostic evaluation	Bill with V1 modifier when providing telephone only services. (pays at 80% of current allowed)
CPT®	90792	Psychiatric diagnostic evaluation with medical services	Bill with V1 modifier when providing telephone only services (pays at 80% of current allowed)
CPT®	90832	Psychotherapy, 30 minutes with patient.	Bill with V1 modifier when providing telephone only services (pays at 80% of current allowed)
CPT®	+90833¹	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	Bill with V1 modifier when providing telephone only services (pays at 80% of current allowed)

¹ (+) Symbol that denotes a specific code that is considered an add-on-code per CPT® definition.

CPT®	90834	Psychotherapy, 45 minutes with patient.	Bill with V1 modifier when providing telephone only services (pays at 80% of current allowed)
CPT®	+90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	Bill with V1 modifier when providing telephone only services (pays at 80% of current allowed)
CPT®	90837	Psychotherapy, 60 minutes with patient.	Bill with V1 modifier when providing telephone only services (pays at 80% of current allowed)
CPT®	+90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the primary procedure)	Bill with V1 modifier when providing telephone only services (pays at 80% of current allowed)
CPT®	90846	Family psychotherapy (without the patient present), 50 minutes	Bill with V1 modifier when providing telephone only services (pays at 80% of current allowed)
CPT®	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	Bill with V1 modifier when providing telephone only services (pays at 80% of current allowed)
CPT®	+90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)	Bill with V1 modifier when providing telephone only services (pays at 80% of current allowed)
CPT®	96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family	Bill with V2 modifier when providing telephone only services (pays at 55% of current allowed)
CPT®	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	Bill with V2 modifier when providing telephone only services (pays at 55% of current allowed)
CPT®	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	Bill with V2 modifier when providing telephone only services (pays at 55% of current allowed)
CPT®	97804	Medical nutrition therapy; group (2 or more individual (s)), each 30 minutes	Bill with V2 modifier when providing telephone only services (pays at 55% of current allowed)

CPT®	98960	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	Bill with V2 modifier when providing telephone only services (pays at 55% of current allowed)
CPT®	98961	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	Bill with V2 modifier when providing telephone only services (pays at 55% of current allowed)
CPT®	98962	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	Bill with V2 modifier when providing telephone only services (pays at 55% of current allowed)
CPT®	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter	MHSUD clinicians bill with V1 modifier when providing telephone only services (pays at 80% of current allowed). Medical clinicians bill with V2 modifier when providing telephone only services (pays at 55% of current allowed).
CPT®	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	MHSUD clinicians bill with V1 modifier when providing telephone only services (pays at 80% of current allowed). Medical clinicians bill with V2 modifier when providing telephone only services (pays at 55% of current allowed).

CPT®	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	MHSUD clinicians bill with V1 modifier when providing telephone only services (pays at 80% of current allowed). Medical clinicians bill with V2 modifier when providing telephone only services (pays at 55% of current allowed).
CPT®	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	MHSUD clinicians bill with V1 modifier when providing telephone only services (pays at 80% of current allowed). Medical clinicians bill with V2 modifier when providing telephone only services (pays at 55% of current allowed).
CPT®	99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	Bill with V2 modifier (pays at 55% of current allowed)
CPT®	99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	Bill with V2 modifier (pays at 55% of current allowed)
CPT®	99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	Bill with V2 modifier (pays at 55% of current allowed)
CPT®	99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	Bill with V2 modifier (pays at 55% of current allowed)
CPT®	99495	Transitional Care Management Services with the following required elements: *Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge *Medical decision making of at least moderate complexity during the service period *Face-to-face visit, within 14 calendar days of discharge	Bill with V2 modifier (pays at 55% of current allowed)

CPT®	99496	Transitional Care Management Services with the following required elements: *Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge *Medical decision making of high complexity during the service period *Face-to-face visit, within 7 calendar days of discharge	Bill with V2 modifier (pays at 55% of current allowed)
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2. Telephone-Only Codes for Evaluation and Management Services

The telephone E/M codes are identified in Table 2 below. Because there are circumstances where benefit plans require these codes to be billed for services delivered via telephone (e.g., patients with Medicare as primary coverage), these codes should be available for use by providers. While the code descriptions indicate the codes are to be used for visits with established patients, Blue Cross is open to allowing these to be billed for new patient encounters as well. With respect to rates, because CPT® 99442 and CPT® 99212 involve similar amounts of time spent with the patient, based on the code descriptions (both for up to approximately 20 minutes of time), the rate for CPT® 99442 should be roughly equivalent to the rate for CPT® 99212 when billed with the V2 modifier. Similarly, because CPT® 99443 and CPT® 99213 involve spending up to approximately 30 minutes of time with the patient, based on the code descriptions, the rate for CPT® 99443 should be roughly equivalent to the rate for CPT® 99213 when billed with the V2 modifier.

Table 2. Telephone E/M codes

Code Type	Code	Description	Reimbursement
CPT®	99441	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; 5-10 minutes of medical discussion	Pay at a rate that takes into account the rates for CPT®s 99442 and 99443 (see below) but maintains relatively among the rates for this code set.

CPT®	99442	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; 11-20 minutes of medical discussion	Pay at a rate comparable to rate for CPT® 99212-V2 paid to specialists
CPT®	99443	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; 21-30 minutes of medical discussion	Pay at a rate comparable to rate for CPT® 99213-V2 paid to specialists

Thank you again for the opportunity to submit this proposal for review. We look forward to your response.



April 29, 2021

Sebastian Arduengo
Assistant General Counsel
Vermont Department of Financial Regulation (DFR)
89 Main Street
Montpelier, VT 05620-3101

Re: Coding and Reimbursement Proposals for Audio-Only Telemedicine Under Act 6 of 2021 (S.117)

COVID-19 Emergency Policies

Throughout the COVID-19 pandemic, MVP Health Care (“MVP”) has provided its more than 40,000 Vermont members with access to telehealth and audio-only services consistent with DFR Emergency Rule H-2020-06-E. MVP is currently covering telephone-only codes as telehealth visits, and reimbursing providers the same as in-person visits under the provider agreement. This policy directs providers to submit the appropriate Evaluation & Management (E/M) or CPT code, as well as modifiers “95” or “GT” appended to the claim to signify that a service is delivered via telehealth. Per your April 2 memo, MVP will continue this policy through the end of plan year 2021.

Post-Pandemic Coding and Reimbursement Recommendations

Medical and Behavioral Health Physicians

Telephone Only Codes—Because providers have been directed to submit claims for telephone only visits as telehealth visits during the COVID-19 emergency, it has been challenging to capture telephone calls as unique encounters. To improve data collection, MVP urges the use of CPT Codes 99441-99443 for future plan years to clearly differentiate these services from those provided in an office setting or via two-way synchronous audio/visual platforms. CPT Codes 99441-99443 are medical procedure codes under the range Non-Face-to-Face Telephone Services that vary by the amount of time a provider spends with a patient.

Reimbursement—MVP urges reimbursement of these claims based on Medicare Relative Value Units (RVUs) using the “02” place of service, consistent with the Centers for Medicaid & Medicare Services (CMS) Physician Fee Schedule. As you know, CMS utilizes RVUs to account for the work involved in services provided, as well as a practice’s overhead in providing that service. For your reference, the 2020 Medicare RVUs for CPT Codes 99441-99443 using an “02” place of service are listed below. Under MVP’s physician fee schedule, providers would be paid at a greater percentage than the standard Medicare fees listed here.

CPT Code	Description	POS 02 RVU
99441	E/M Physician/QHP 5-10 min	\$25.65
99442	E/M Physician/QHP 11-20 min	\$51.24
99443	E/M Physician/QHP 21-30 min	\$79.00

Flexibility—MVP encourages DFR to preserve flexibility for plans and providers around contracting for these services. For example, as we gather more data and experience, MVP might choose to reimburse certain providers at equal or greater amounts than those prescribed in the CMS Physician Fee Schedule for the CPT codes outlined above where there is clear clinical value for patients. Additionally, MVP would need flexibility to ensure that these codes cannot be “gamed” to drive higher aggregate payments for services delivered by telephone versus other settings. For example, if a provider were to bill an hour’s worth of services using CPT Code 99441, they could receive over \$300 in reimbursement, which is likely higher than what they would receive for a standard office visit. Flexibility is important to preserve the integrity of the provider network and delivery of high-value care.

Non-Physician Behavioral Health Provider Services

For non-physician behavioral health services, MVP urges DFR to align with national standards by utilizing existing CPT language and definitions for its future plan year guidance. Importantly, this approach will ensure consistency across commercial and public payers and reduce administrative complexity for providers.

MVP plans to continue reimbursing behavioral health providers (non-physician) at parity regardless of how those services are delivered beyond plan year 2021. Throughout the pandemic, we've seen particular value of telehealth and audio-only options for patients with behavioral health needs. There is a shortage of these services and providers in normal times, and the pandemic has only heightened patients' clinical needs. If DFR plans to require payment parity for any particular service, it should consider doing so for these behavioral health care services.

Notably, CPT Codes 99441-99443 are not designed for non-physician behavioral health services. As such, MVP favors a continuation of its COVID-19 policy, where these providers are instructed to submit CPT codes with the appropriate place of service and claim modifiers "95" or "GT."

Discussion

In determining reimbursement amounts, Act 6 charges DFR with seeking "a reasonable balance between the costs to patients and the health care system and reimbursement amounts that do not discourage health care providers from delivering medically necessary, clinically appropriate services by audio-only telephone." MVP feels that the recommendations outlined above accomplish this important balance.

MVP supports reimbursement parity for audio-only telephone calls during the COVID-19 pandemic to ensure that our provider partners can deliver, and our members can access, vital health care services. Beyond the pandemic, however, it is important to incentivize delivery of high-value care for the benefit of patients and the broader health care system. Where possible, we should encourage patients to seek care in-person or via synchronous audio/visual platforms and incentivize providers to treat patients in these higher-value settings. To that end, reimbursement policies are important tools.

Much of the public policy discussion on this issue has been framed around what constitutes "adequate" reimbursement. However, these are services that were not covered or reimbursed before the COVID-19 pandemic. When the emergency is lifted, Act 6 will enable providers to connect with patients in new ways and receive payment for those services. So, even if audio-only telephone calls are reimbursed at a lesser amount for some services, there is greater opportunity for all providers to improve patient care, coordination, and overall quality from new revenue opportunities that did not exist before March 2020.

Questions

Thank you for the opportunity to comment. Please contact me with any follow up questions, or for further discussions with the MVP team.

Sincerely,

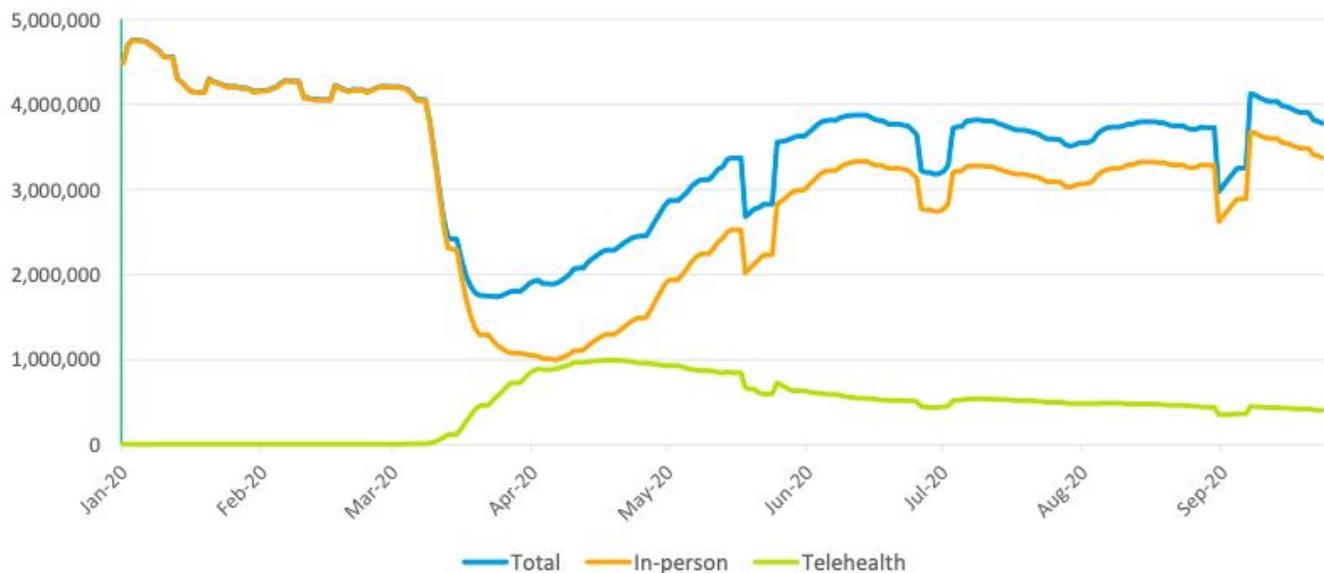


Jordan T. Estey
Senior Leader, Government Affairs

Changes in Medicare Physician Spending During the COVID-19 Pandemic

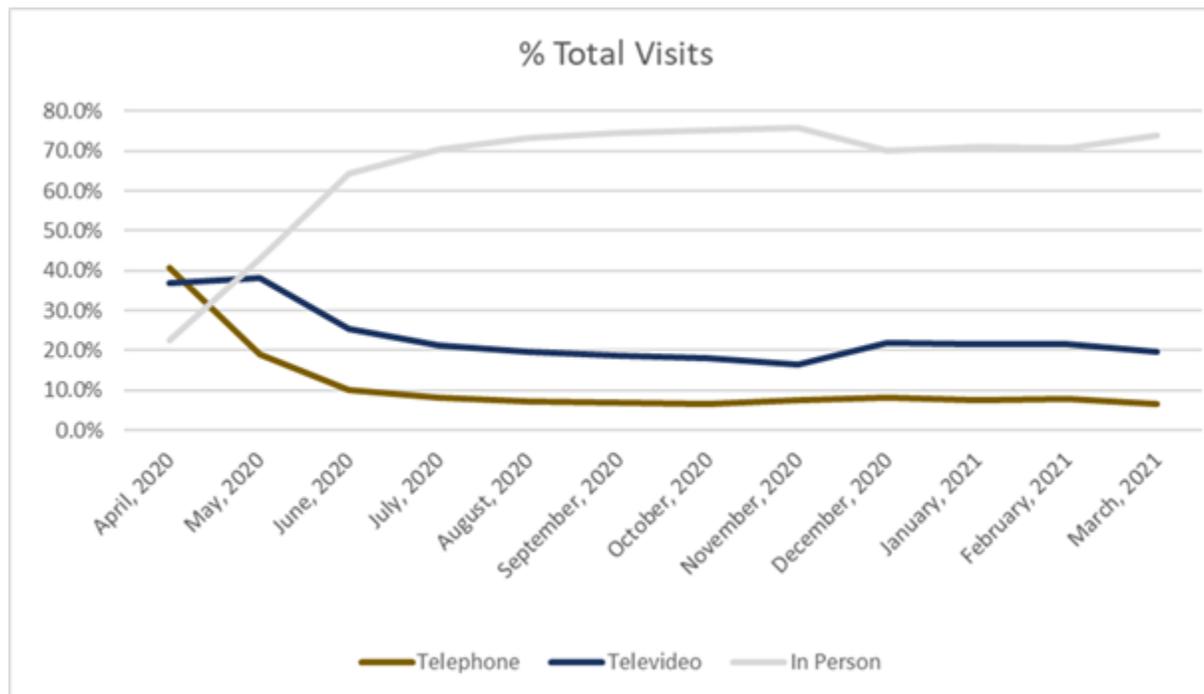
Economic and Health Policy Research, American Medical Association, April 2021

Number of Established Patient Office Visits Per Week



Vermont Hospital Volume Trends – University of Vermont Health Network

At the start of the pandemic, University of Vermont Health Network (UVM HN) experienced a dramatic drop in overall visits and a dramatic increase in telehealth visits. In the telehealth visits, audio-only services were particularly important at the start of the pandemic disruption. However, visits quickly recalibrated, with in-person returning to the vast majority of visits and audio-only to a small percentage.



Vermont Hospital Volume Trends – University of Vermont Health Network

The table below shows more detail, with a volume comparison during the same four month period (November through March) 2019 to 2020 and 2020 to 2021:

	Monthly Baseline	% Baseline	% Telephone	% Televideo	% In Person
CVMC	71,463	93%	9%	17%	75%
PMC	30,415	90%	8%	6%	86%
UVMMC	239,525	97%	7%	20%	72%
Total	341,403	100%	7%	20%	72%

- Monthly Baselines are total volume from November, 2019 through March, 2020
- % Baseline is the comparison between the above volume and total volume from November, 2020 through March, 2021
- % appointment types are based on volume from November, 2020 through March, 2021

The table below shows total volume during this time period:

	Total				CVMC				PMC				UVMMC			
	Telephone	Televideo	In Person	Total	Telephone	Televideo	In Person	Total	Telephone	Televideo	In Person	Total	Telephone	Televideo	In Person	Total
November, 2020	4,119	9,134	41,816	55,069	1,064	1,634	10,111	12,809	352	276	5,016	5,644	2,703	7,224	26,689	36,616
December, 2020	5,606	15,426	49,118	70,150	1,390	2,794	11,063	15,247	602	420	5,825	6,847	3,614	12,212	32,230	48,056
January, 2021	5,732	16,037	53,172	74,941	1,362	2,813	11,525	15,700	569	452	5,951	6,972	3,801	12,772	35,696	52,269
February, 2021	5,437	15,359	49,942	70,738	1,435	2,815	11,146	15,396	548	469	5,277	6,294	3,454	12,075	33,519	49,048
March, 2021	5,755	17,288	64,757	87,800	1,344	2,978	13,531	17,853	635	526	6,881	8,042	3,776	13,784	44,345	61,905
	26,649	73,244	258,805	358,698	6,595	13,034	57,376	77,005	2,706	2,143	28,950	33,799	17,348	58,067	172,479	247,894

Anecdotally, one of the drivers of audio-only volume is patient visits that convert from audio-visual to audio-only when there are technology problems – the modality reflects how the visit was *completed* not how it was scheduled or initiated. For this reason, there was a concern about patient satisfaction and audio-only. Study of patient engagement data shows that patient satisfaction with audio-only is not significantly lower than other modalities (it does lag somewhat, as predicted if visits with technical difficulties appear in that bucket) and the satisfaction scores are overall quite high –above 85%. These results suggest that audio-only is serving its intended purpose of improving access to care. (See graphs on the following page).

Vermont Hospital Volume Trends – University of Vermont Health Network





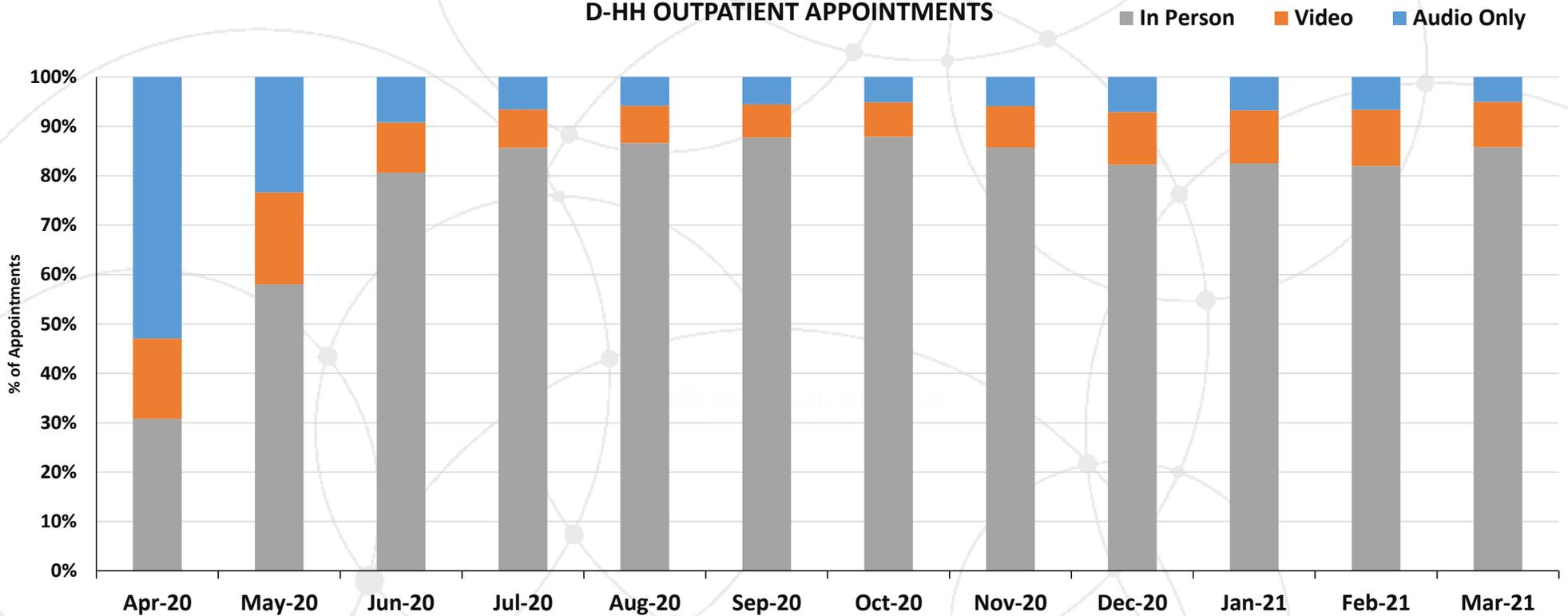
Dartmouth-Hitchcock
CONNECTED CARE

OUTPATIENT VIRTUAL VISITS

COVID-19 through March 2021

TeleEmergency • TeleICN • TeleICU • TeleNeurology • TelePharmacy • TelePsychiatry • TeleUrgent Care • Outpatient Virtual Visits

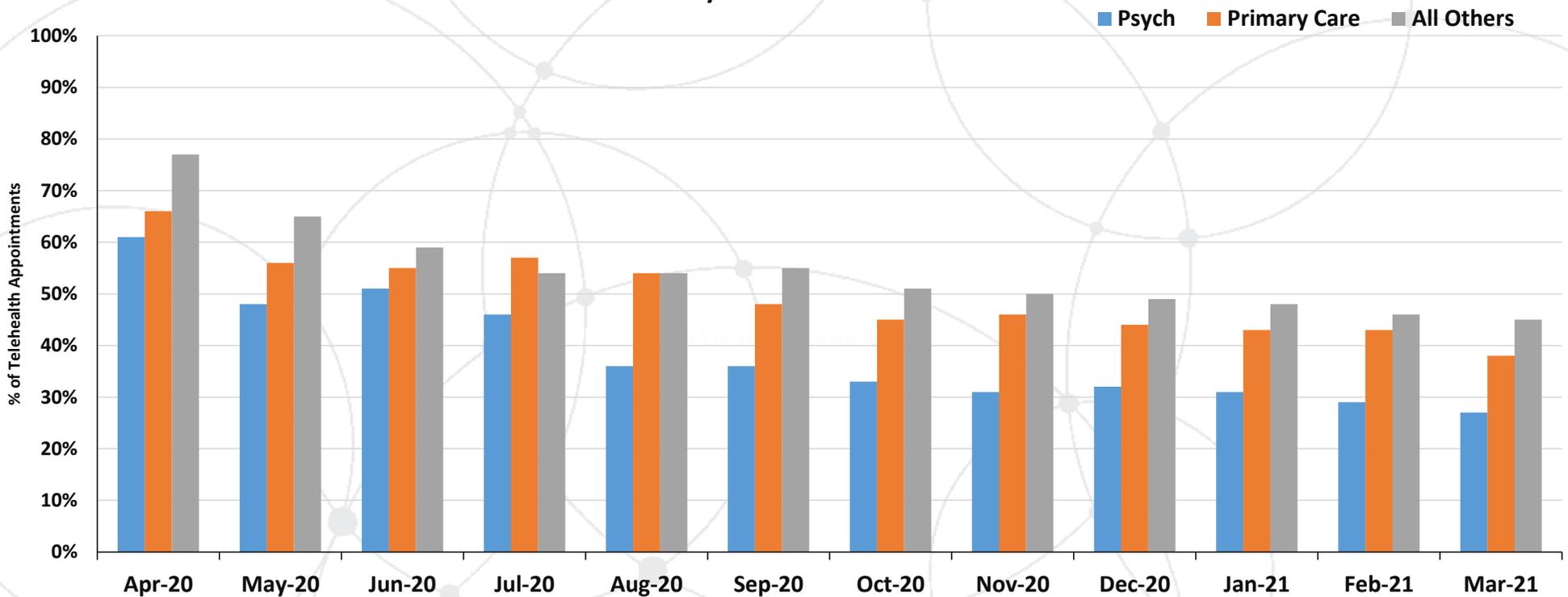
D-HH OUTPATIENT APPOINTMENTS



We did not start tracking modality (video vs phone) as actually delivered (vs. how scheduled) until mid-April; % of audio only appointments in April therefore is over-stated

TeleEmergency • TeleICN • TeleICU • TeleNeurology • TelePharmacy • TelePsychiatry • TeleUrgent Care • Outpatient Virtual Visits

AMC Telehealth Appointments by Audio Only by Service Line



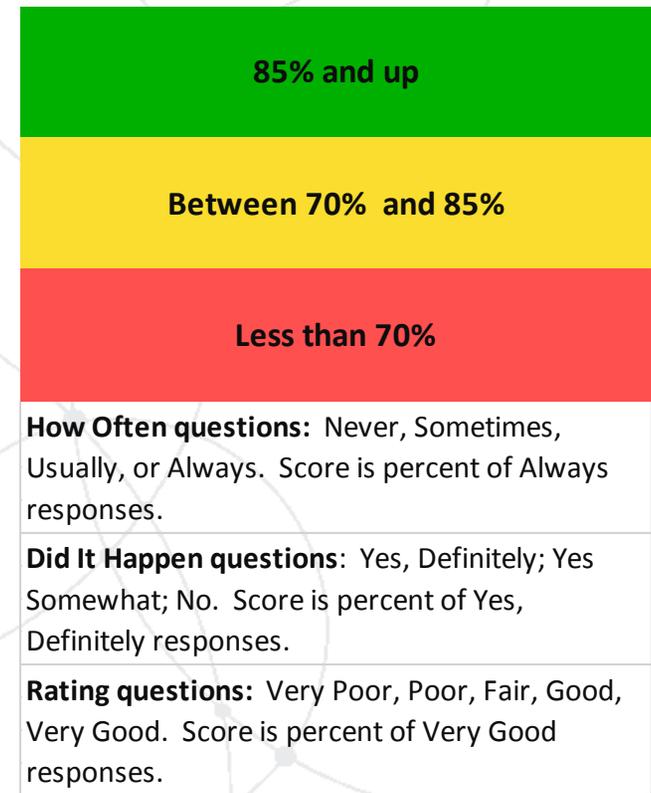
Audio-only telehealth is an important option beyond Behavioral Health Services

TeleEmergency • TeleICN • TeleICU • TeleNeurology • TelePharmacy • TelePsychiatry • TeleUrgent Care • Outpatient Virtual Visits

Outpatient Satisfaction (Press-Ganey Survey) - FY 21 YTD

Question (short)	In Person	Telehealth
Right away appt as soon as needed	Green	Green
Routine appt/chk-up soon as needed	Green	Green
Give easy to understand instruction	Green	Green
Know important info medical history	Green	Yellow
Provider expl in way you understand	Green	Green
Provider listen carefully to you	Green	Green
Show respect for what you say	Green	Green
Spend enough time with you	Green	Green
Would recommend provider's office to others	Green	Green
Rate ease of contacting clinic (email, phone, portal)	Red	Red
Rate ease of scheduling your appointment	Red	Yellow
Likelihood of recommending this practice to others	Green	Yellow
Likelihood of recommending this provider to others	Green	Green
Rate concern provider showed for your questions	Green	Green
Rate explanations provider gave	Yellow	Yellow
Rate provider included you in care decisions	Green	Green
Rate provider's discussion of any proposed treatment	Yellow	Yellow
Rate how well staff worked together	Yellow	Yellow
Rate ease of talking with provider virtually	White	Yellow
Rate how well audio connection worked	White	Yellow
Rate how well video connection worked	White	Yellow

"Top Box Score"



Outpatient Satisfaction – Selected Patient Comments

Getting to DHMC in the winter is hard for me - this was easy and helpful

Given the nature of my visit, consultation without need for examination, I thought it was a perfect arrangement

Telemedicine was a great time-saving option for me as my travel time to the office is over an hour drive one-way

This was a good option given I could not physically make it to my doctor visit – I am grateful my appointment did not have to be rescheduled

We shared a phone conversation, not a virtual visit – I actually prefer the phone over the virtual visit for this kind of communication

Being my first ZOOM experience, I was apprehensive, but it all worked out well; next time I will be much more comfortable with this format

I think this is a plus to come from COVID; hopefully we will be able to continue this after

Overall, the virtual visit was just as positive and productive as an in person appointment

I felt totally satisfied and was saved the time of an in-person visit

Telehealth Data for Vermont Federally Qualified Health Centers

(Compiled in April, 2021)

Bi-State reviewed aggregated utilization data for Vermont FQHCs to check for impacts of audio-only telehealth reimbursement on use of health care resources.

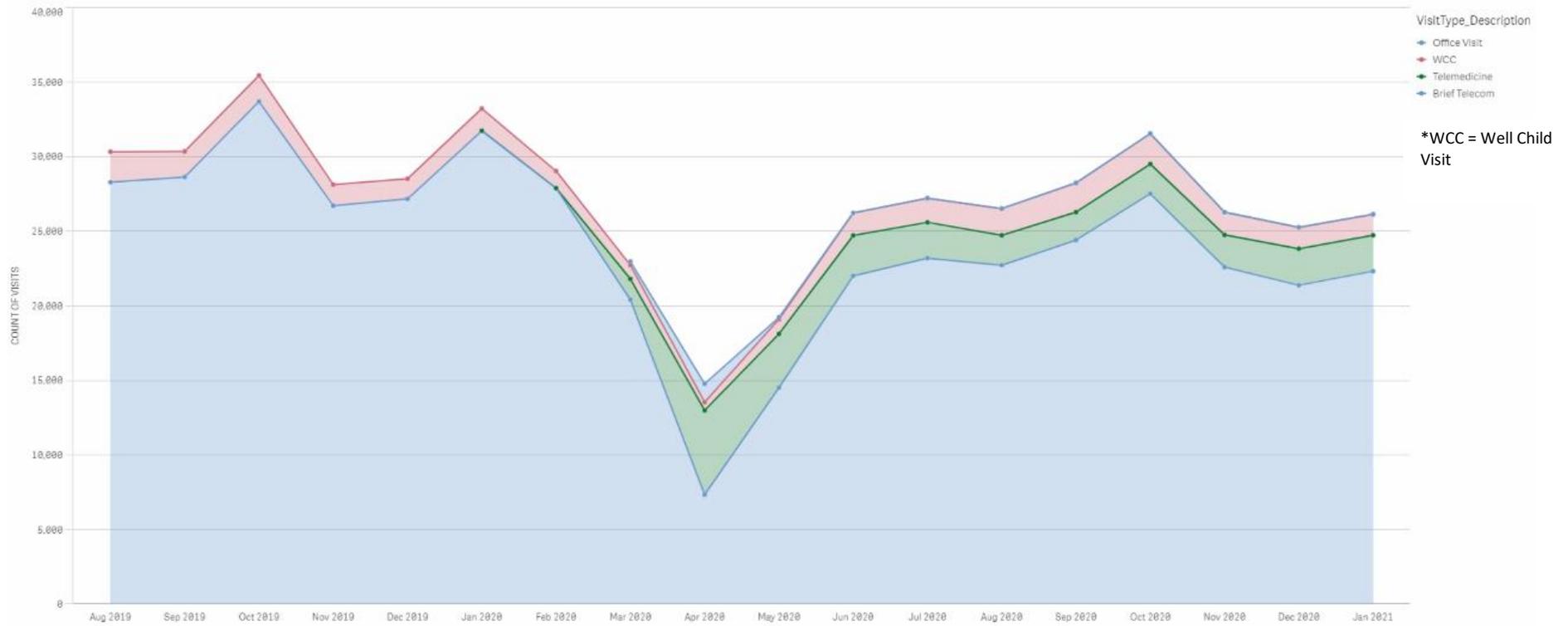
We eliminated two health centers – one because we did not have their data, the other because we did not have accurate categorization of telehealth vs. in-person. For the latter health center, we did check that their *overall* utilization patterns followed those seen elsewhere in the state, and they did.

The remaining 9 health centers included in the following charts provide primary care to approximately 130,000 patients.

Although we include audio-only calls as their own category in the following two charts, we are not confident in the consistency of this coding. These primarily represent “triage” calls – not regular health care services delivered via audio-only modality. This data does show the importance of those brief calls during the most intense months of the initial COVID-19 wave. These codes are only billed when a follow up visit is determined to be unnecessary, so each of those data points represents an unnecessary visit diverting during a time when we wanted to limit potential COVID-19 exposure.

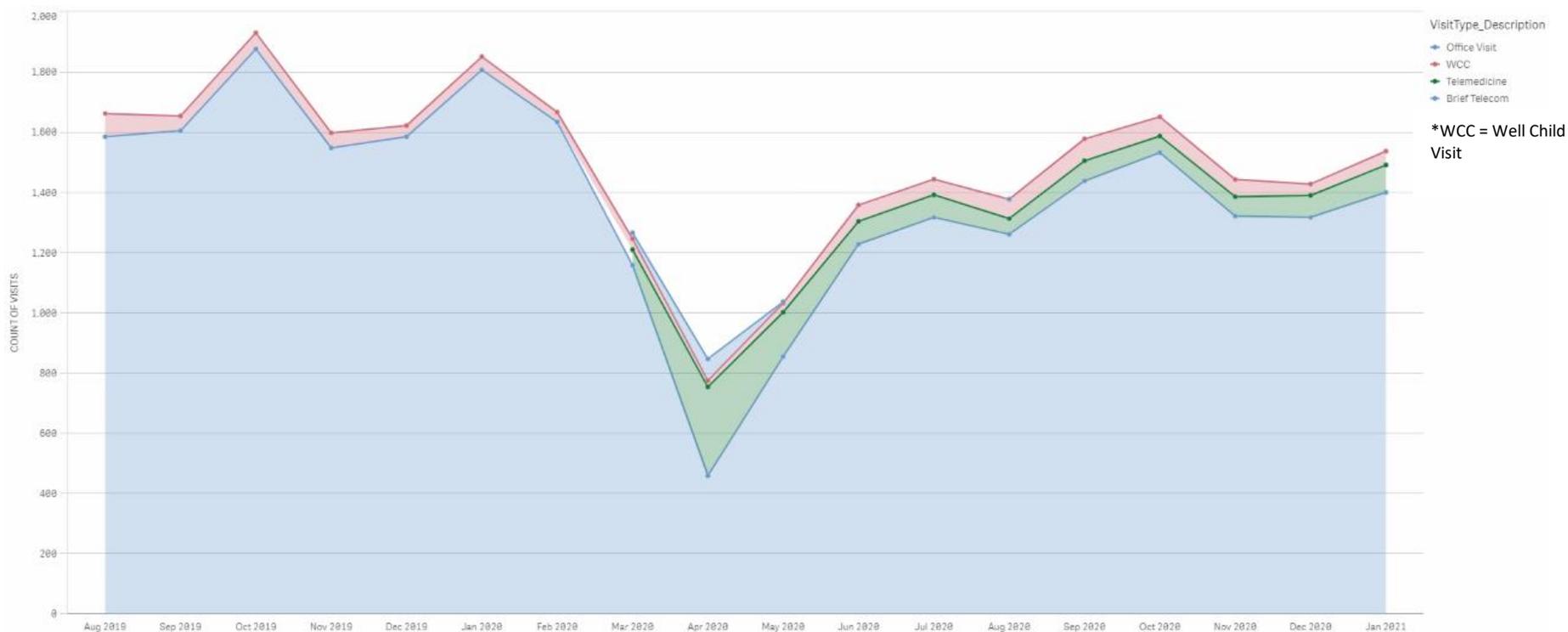
The following page shows overall utilization for medical appointments. We see a precipitous drop-off in patient visits of all types in March / April of 2020, and a significant overall increase in telehealth. We also see a drop off in the types of visits that cannot easily be performed via remote care (well child visits are our proxy for this, shown on the following graph). Following the spring of 2020, the visits rebound but do not fully recover. Telehealth as an overall portion of visits reduces and stabilizes, increasing again slightly in late fall when Vermont experiences a second wave of COVID-19.

Utilization – All Patients



MVP created a miniature natural experiment because they, unlike other payers, waived all cost-shares on telehealth during the Public Health Emergency. This move created an additional financial incentive for patients to elect telehealth over in-person care. In spite of that incentive, we do not see a major impact on the patterns. However, it is a *much* smaller subset of patients and a short time period with many conflating factors, so there is a limit to what conclusions we can reach.

Utilization – Patients with MVP Insurance



In spring, 2021, FQHCs began to play a major role in COVID-19 vaccination efforts, which both sent our volume of patient visits much higher and the visits required in-person service. The above graphs do not include those months. We also do not include the flu vaccination clinics in the previous data, which were much more robust in fall 2020 than typical years, or COVID-19 testing. These are all public health initiatives for services that must be done in person. When we expand the services included to reflect these efforts, we see the following utilization.

Utilization – Expanded Range of Services



Here we can see a major spike in fall with a confluence of flu clinics and increased COVID-19 prevalence, and a sharp uptick in spring as FQHCs take on a leading role in COVID-19 vaccination. These data do show periods of upward swings in utilization that are sharper than in pre-COVID times, but that difference can be explained by public health initiatives – it is not attributable to telehealth or audio-only telehealth, which continue to be a very low percentage of health care services.

We also know that COVID-19 touched off a major demand for mental health services among our patients. The patient demographic for FQHCs includes many households who experienced additional stressors during the pandemic – for example concern about accessing food or about losing a job – and these stressors also fueled a demand for mental health services. When we add in these services to our previous medical utilization chart, we see that during the shutdown period in spring 2020, when telehealth was the preferred modality for safety reasons, mental health added a significant volume of use. The reliance on telehealth decreases after that initial surge, but it is decreasing from a much higher point and remains proportionally larger. This utilization was clearly driven by organic demand stemming from the pandemic, not from telehealth reimbursement structures. Again, it is COVID-19 related factors driving utilization patterns, not telehealth modalities – telehealth is a tool to meet access needs.

Utilization – With Mental Health Services



April 30th, 2021

Re: Act 6 Stakeholder Memo – comments by the coalition of health care associations

To: Sebastian Arduengo, Department of Financial Regulation

Thank you for the opportunity to comment on appropriate billing codes and reimbursement rates for audio-only health care services provided through January 1, 2025.

As previously expressed in testimony, the coalition representing health care providers in our state emphatically supports parity reimbursement for audio-only telephone services. We support the current extension of Regulation H-2020-06-E, and support continuing the reimbursement rates established in that regulation through the end of the 2024 plan year.

The experience of our providers is that audio-only connections offer critical access to care for patients who face barriers that might otherwise cause them to delay, defer, or cut short medical treatment. These barriers exist outside of the pandemic. However, the pandemic highlighted the number of patients for whom technological barriers (broadband access, affordability, computer equipment, and/or comfort with technology) make an audio-visual connection impractical. It has also pushed to the fore our understanding for the appropriate clinical circumstances for different telehealth modalities. Through supporting audio-only services, we have the opportunity to offer care that was previously inaccessible, and we need to keep that pathway open.

Our members are not experiencing a cost savings as part of implementing audio-only. In fact, many report that it takes more time. The additional time costs come from working with patients to determine if audio-only is appropriate; helping patients get situated in a new way of connecting with their providers, including talking through their different options; more time spent by the clinician in the appointment talking through each patient concern and checking that nothing has been missed; more time spent documenting the encounter. The patients who require audio-only access are by definition weighted towards those who are caught on the wrong side of the digital divide and who face barriers to reaching in-person care. For this reason, staff also spend more time working with patients on options to address these barriers – our goal is to make sure the first connection happens *and also* that all appropriate follow-up care takes place. We are creating a critical pathway to care that didn't exist before, and that takes considerable work.

Some of the above cost elements will fade as new systems become standard practice. We can also anticipate that more effective use of telehealth tools will allow for more patients to be seen in a given health care site, reducing per patient overhead costs. However, it will take multiple years before those savings are realized. They are currently just theoretical. It is reasonable to expect that parity will be needed at least through 2024.

Health care organizations and their associations continue to work to make implementation of audio-only services as smooth as possible for practices and patients. We are providing technical assistance for immediate implementation of updated patient informed consent rules. We are participating in statewide conversations around how to address the digital divide, and supporting members in applying for grants and equipment to directly serve their patients who have difficulty

connecting to traditional telemedicine. We are partnering with VPQHC and the Northeast Telehealth Resource Center on training opportunities and technical assistance. We are setting the foundation for health care providers in Vermont to flourish in a value-based telehealth reimbursement system in 2025, but we cannot lose the momentum by reducing reimbursement for virtual care today – such a move would send a clear signal to our providers that they should not invest in this future mode of health care.

We want to strike a correct balance of a reimbursement level that signals to practices to continue offering virtual services and make those services available to all patients, without reimbursing so much that we incentivize practices to *overutilize* telehealth. Looking at basic utilization data over the last year, we see no sign of over-use. We have attached details from Bi-State Primary Care Association, University of Vermont Health Network and Dartmouth-Hitchcock Health. In general, the trends have been as follows:

- Significant drop off in overall visit volume in the first wave of shut-downs, and significant increase in telehealth as a percent of visits that do occur.
- Over the summer, a rebound in overall volume (although not to 100%) and significant decrease in telehealth as a percentage of visits.
- With the second COVID-19 wave in late fall of 2020, an uptick in telehealth use, but nothing as dramatic as in spring of 2020.
- A steady decrease in audio-only as a percent of telehealth services following the spring of 2020. Overlaid on a general reduction in telehealth use, this means a small number of appointments using audio-only services.
- Organizations with multiple services lines see a need for audio-only across their practice. We want to emphasize that even if audio-only drops to a very small absolute number of visits for some providers, those connections are critical for the patients who use them.

These trends are what we would predict for appropriate telehealth use. We also see these general trends reflected in national Medicare claims. We see no evidence that audio-only parity reimbursement will become a driver for increasing remote services beyond what is appropriate for allowing patients to access care in the way that best meets their needs.

Collecting better data on telehealth modalities will allow Vermont to monitor trends and to design future payment systems. We believe that the update to CPT terminology in 2021 clarifies the applicability of those codes to remote services. We recommend that claims for audio-only telephone services use the relevant service code, with a modifier to indicate services delivered remotely and that they were delivered via an audio-only platform. We strongly encourage alignment between Medicaid and commercial payer modifiers if possible in their respective systems. This coding recommendation applies to audio-only services delivered as equivalent to in-person services, not to telephone-specific codes, such as G2012.

See additional attachments:

Bi-State Primary Care Association 2020 & 2021 Telehealth Data
Dartmouth-Hitchcock Health 2020 & 2021 Telehealth Data
UVM Health Network 2020 & 2021 Telehealth Data
Medicare Telehealth Trends – AMA Graphic

Thank you for considering this input as you make your next reimbursement and coding decisions.

Sincerely,

Devon Green
VP, Government Relations
Vermont Association of Hospitals and Health Systems

Jill Mazza Olson
Executive Director
VNAs of Vermont

Laura Pelosi, on behalf of
Vermont Health Care Association
Bayada Home Health and Hospice

Julie Tessler
Executive Director
Vermont Care Partners: VT Council

Georgia J. Maheras
Vice President of Policy & Strategy
Bi-State Primary Care Association

Jessa Barnard
Executive Director
Vermont Medical Society

Dr. Norman Ward
Chief Medical Officer
OneCare Vermont

Patrick Gallivan
Executive Director
Vermont State Dental Society

Matthew Houde
Vice President of Government Relations
Dartmouth Hitchcock-Health

Stephanie Winters
Executive Director
Vermont Psychiatric Association
Vermont Academy of Family Physicians
American Academy of Pediatrics - Vermont
Chapter

Virginia Renfrew, on behalf of
Vermont Association of Naturopathic Physicians

Jason Williams
Network Director, Government and
Community Relations
The University of Vermont Health Network