July/August 2026 Advisory

Reminder For Supervised Billing And Payment

The Department of Vermont Health Access (DVHA) and Gainwell Technologies would like to remind providers of the new supervised billing requirements that went into effect on January 1st, 2026, for billing and payment.

When submitting claims to DVHA for reimbursement:

- The supervisor must be listed as the billing provider
- The supervisee must be listed as the attending/rendering provider
- Modifiers HO, HN, HM, AJ or AH are not required
- If telehealth service is rendered, a telehealth modifier is required
    - If audio/video use modifier 95
    - If audio only use modifier 93

DVHA will reimburse the supervising provider for services rendered, as they are the licensed provider in the State of Vermont.

Special Investigations Unit (SIU) Reminder

The Special Investigations Unit (SIU) of the Department of Vermont Health Access (DVHA) safeguards against unnecessary or inappropriate use of Medicaid services, excess payments, and provides for the control of utilization of services under Vermont's health care programs. Providers are required to bill Medicaid correctly and in an effort to assist them with proper billing of Medicaid services, we have identified the following reminder:

Evaluation & Management (E/M) Services During a Shared Medical Appointment

Evaluation and Management (E/M) services are provided by a physician or other qualified healthcare professional for the purpose of diagnosing and treating illnesses, diseases or injuries for an individual. The American Medical Association (AMA) Current Procedural Terminology (CPT) has specific guidelines that dictate how E/M services should be reported when provided by

qualified health care providers. The E/M guidelines have sections that are common to all E/M services and other sections that are category specific. The E/M guidelines are to be used to select the appropriate level of service by the physician or other qualified healthcare professional reporting the service for the individual patient.

Per the AMA CPT Evaluation and Management Code and Guideline Changes 1/1/23, Medical Decision Making (MDM) includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are the number and complexity of problem(s) that are addressed during the encounter; the amount and/or complexity of data to be reviewed and analyzed; the risk of complications and/or morbidity or mortality of patient management.

There are four levels of MDM (i.e., straightforward, low, moderate, high). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded. See established E/M office visit CPT codes below:

- **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.
- **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.
- **99214**-Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **moderate level** of medical decision making.
- **99215**-Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **high level** of medical decision making.

When another separately identifiable service is performed on the same day as an E/M service, the documentation for each service must be independent of one another and within the individuals' scope of practice. Each note must stand alone. There cannot be overlap of the documentation used to support the two distinct services. When billing for group psychotherapy services, each person attending the group session must have a written record detailing what occurred during that session. Time spent providing psychotherapy must be documented separately from the E/M service and not include the activities of the E/M service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply **require a face-to-face encounter** with the **physician** or **other qualified health care professional** and the **patient**. Documentation must support the time selected.

The AMA and Centers for Medicare and Medicaid Services (CMS) do not prohibit providing E/M services to patients that are observed by another patient. To bill for E/M services the following documentation requirements must be met or exceeded: a chief complaint, medically appropriate history and/or physical exam when performed as well as MDM. All components must be documented by a physician or other non-physician provider. Components rendered by other non-qualified providers cannot be used or applied towards the level of service. CMS also indicates that

activities of the group (including group counseling activities) should not impact the level of code reported for the patient, meaning all individuals must have a stand-alone note and be billed using the medical level of service supported by documentation. Prescription medication management alone does not support the use of a moderate level of MDM. The elements for the number and complexity of problem(s) that are addressed during the encounter and the amount and/or complexity of data to be reviewed and analyzed must be addressed by the appropriate provider type acting within their scope of practice. All split-shared and incident-to billing requirements apply.

Per AMA CPT: "When time is being used to select the appropriate level of services for which time-based reporting is allowed, the time personally spent by the physician(s) and other qualified health care professional(s) assessing and managing the patient and/or counseling, educating, communicating results to the patient/family/caregiver on the date of the encounter is summed to define total time." Time spent participating in group setting/activities for a shared medical visit should not be used to report on the level of E/M service. Additionally, when using time to select the level of service, only the time spent on the actual date of the encounter can be counted towards total time. This includes only the minutes from the start of the day's services to the end, not across multiple calendar dates.

Vermont Medicaid does not recognize private payer insurance's policy as a standard for primary payment. Vermont Medicaid only pays for medically necessary services and providers may not select an E/M code during a shared medical visit based solely on the time spent with each patient as an E/M is used for delivery of medical services and not purely based on counseling or coordination of care.

References:

- American Medical Association (AMA) Current Procedural Terminology (CPT) Section Guidelines
- Department of Vermont Health Access General Provider Agreement
- VTMedicaid.com/#/manuals