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TELEMEDICINE PAYMENT POLICY
Corporate Payment Policy
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Document Precedence

The Blue Cross and Blue Shield of Vermont ("BCBSVT") Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member contracts and employer benefit documents, provider contracts, BCBSVT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the Plan's claim editing solution, the Plan's claim editing solution shall take precedence.

Payment Policy

Description

Vermont law requires health insurance plans to provide coverage and pay for health care services delivered through telemedicine by a health care provider at a distant site to a patient at an originating site to the same extent the health insurance plan would cover and pay for the services if they were provided through in-person consultation.[1] In anticipation of changes we expect to Vermont law, BCBSVT reimburses for health care services and dental services delivered by store-and-forward means.[2]

[1] 8 V.S.A. § 4100k(a).
[2] See proposed revisions to 8 V.S.A. § 4100k(e)(1) in Vermont House Bill 723 (2020).

Vermont law[3] defines the following terms as noted below:

"Telemedicine" means "the delivery of health care services, including dental services, such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191."[4]

"Distant site" means "the location of the health care provider delivering the services through telemedicine at the time the services are provided."[5]

"Health care facility" is defined by 18 V.S.A. § 9402(6).[6]

"Health care provider" means "a person, partnership, or corporation, other than a facility or institution, that is licensed, certified, or otherwise authorized by law to provide professional health care services, including dental services, in this State to an individual during that individual's medical care, treatment, or confinement."[7]

"Originating site" means "the location of the patient, whether or not accompanied by a health care provider, at the time services are provided by a health care provider through telemedicine, including a health care provider's office, a hospital, or a health care facility, or the patient's home or another nonmedical environment such as a school-based health center, a university-based health center, or the patient's workplace."[8]

"Store and forward" means "an asynchronous transmission of medical information, such as one or more video clips, audio clips, still images, x-rays, magnetic resonance imaging scans, electrocardiograms, electroencephalograms, or laboratory results, sent over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 to

[3] BCBSVT expects the current version of 8. V.S.A. §4100k will be updated as reflected in Vermont House Bill 723 (referred to herein as H.723). In anticipation of these changes becoming law, we have included the definitions and rules in the house bill in this updated version of the payment policy.
[4] Note that although the current definition of "telemedicine" does not include dental services, the version of 8 V.S.A. § 4100k(i)(7) in H.723 (2020) does.
[5] See the version of 8 V.S.A. § 4100k(i)(1) in H.723 (2020).
[6] See the version of 8 V.S.A. § 4100k(i)(3) in H.723 (2020) (""Health care facility" shall have the same meaning as in 18 V.S.A. §9402."); 18 V.S.A. §9402(6) (""Health care facility" means all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all institutions included in subdivision 9432(8) of this title, except Health Maintenance Organizations."); 18 V.S.A. §9432(8) (listing hospitals, including general hospitals, mental hospitals, chronic disease facilities, birthing centers, maternity hospitals, and psychiatric facilities including any hospital conducted, maintained, or operated by the state of Vermont, or its subdivisions, or a duly authorized agency thereof, as well as nursing homes, home health agencies, outpatient diagnostic or therapy programs, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories, cardiac catheterization laboratories, radiation therapy facilities, or any inpatient or ambulatory surgical, diagnostic, or treatment center.)
[7] See the version of 8 V.S.A. § 4100k(i)(4) in H.723 (2020).
[8] See the version of 8 V.S.A. § 4100k(i)(5) in H.723 (2020).

be reviewed at a later date by a health care provider at a distant site who is trained in the relevant specialty. In store and forward, the health care provider at the distant site reviews the medical information without the patient present in real time and communicates a care plan or treatment recommendation back to the patient or referring provider, or both."[9]

BCBSVT may contract with a telehealth vendor for the provision of telemedicine services to Plan members. Under this arrangement, the telehealth vendor supplies a network of health care providers that Plan members access through the vendor's HIPAA-compliant communications system. The vendor submits claims to BCBSVT directly for services rendered. Note that although Vermont law requires a health insurance plan to provide the same reimbursement rate for services regardless of whether the services was provided through an in-person visit or through telemedicine, this requirement does not apply to services provided pursuant to the health insurance plan's contract with a third-party telemedicine vendor.[10]

Policy

A. Synchronous

BCBSVT will reimburse an in-network health care provider, located at a distant site, for health care services delivered through telemedicine to the extent the health care services are:

- Covered by the member's benefit plan;
- Clinically appropriate for delivery through telemedicine, as defined by any applicable laws, rules, or policies; and
- Delivered through the use of live interactive audio and video over a secure connection that complies with the requirements of HIPAA.

The coding table appended as Attachment 1 to this policy outlines the services BCBSVT reimburses for when delivered via telemedicine or store and forward means. A provider must comply with any state or local licensing rules that apply to the delivery of telemedicine services.[11] Plan reserves the right to deny a claim if the provider has not satisfied applicable licensing requirements. In addition, for the treatment of substance use disorder when the originating site is an in-network health care facility, Plan will reimburse both the health care provider at the distant site and the health care facility at the originating

[9] See the version of 8 V.S.A. § 4100k(i)(6) in H.723 (2020).
[10] See the version of 8 V.S.A. § 4100k(a)(2) in H.723 (2020).
[11] Section 4 of the Policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine, adopted by the Vermont Board of Medical Practice on May 6, 2015, available at https://www.healthvermont.gov/sites/default/files/documents/2016/12/BMP_Policies_Vermont%20Telemedicine%20Policy_05062015%20.pdf states: "A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care." Although the policy only explicitly refers to physicians, Vermont law defines "health care provider" in the context of telemedicine, to be a "person, partnership, or corporation, other than a facility or institution, that is licensed, certified, or otherwise authorized by law to provide professional health care services in this State to an individual during that individual's medical care, treatment, or confinement," 8 V.S.A. §4100k(i)(4), which appears to follow a similar policy (that the clinician be licensed where the patient is located).

site for the services rendered unless the health care providers at both the distant and originating sites are employed by the same entity.[12]

Plan reserves the right to request from the provider evidence of the member's informed consent to receive services via telemedicine technology.[13]

B. Asynchronous

BCBSVT will pay for services delivered via store-and-forward means within the following parameters:

- If Provider A has a visit with a member (in-person or via synchronous telemedicine), Provider A may bill for the services that Provider A rendered to the member and collect any cost share associated with that visit, even if Provider A also decides to arrange for store-and-forward telemedicine with Provider B regarding the member's care.
- If Provider A sends information to Provider B via store-and-forward means, Provider A must obtain informed consent from the member. Provider A should not bill BCBSVT for that provision of information, nor should Provider A bill the member. Provider B may bill for services provided and may collect applicable amounts due from the member in cost share.
- Provider B, who receives the information via store-and-forward means and renders an opinion or provides a care plan:
    - Will bill for Provider B's services using the appropriate service code along with modifier - GQ
    - Should bill BCBSVT if Provider B is located in Vermont or contracted with BCBSVT and is eligible to bill BCBSVT directly. If Provider B is located outside of Vermont, Provider B should bill the local Blue Plan for the service. The local Blue Plan may or may not reimburse for store-and-forward telemedicine.
    - Should follow the licensing and telemedicine requirements that apply to the location where Provider B is located.
- A member has the right to refuse to receive services delivered via store-and-forward means and request services in an alternative format (including real-time telemedicine services or in-person services).
- A member's receipt of services does not preclude the member from receiving real-time services or in-person services for the same condition.

C. Third-party Telehealth Vendor

For telemedicine services delivered to Plan members through a Plan-contracted telehealth vendor, Plan will reimburse the vendor according to the contract between Plan and vendor. The health care services must be covered by the member's benefit plan and clinically appropriate for delivery through telemedicine. The services may be provided to a Plan member located outside of Vermont at the time of service so long as the vendor ensures the rendering provider complies with any applicable local or state

[12] See the version of 8 V.S.A. §4100k(h) in H.723 (2020).
[13] 18 V.S.A. §9361 requires a provider delivering health care services through telemedicine to obtain and document a patient's oral or written informed consent for the use of telemedicine technology prior to delivering the services to the patient.

licensing rules.[14] The services must be delivered through the use of live interactive audio and video over a secure connection that complies with the requirements of HIPAA. In situations where a Plan member accesses telemedicine services for substance use disorder through a Plan-contracted telehealth vendor while the Plan member is located in an in-network health care facility, Plan will reimburse the health care facility at the originating site only where (1) the telehealth vendor's provider is not employed by the same entity as the health care facility at the originating site, and (2) the health care facility at the originating site facilitated the Plan member's use of the telehealth vendor's services by supplying equipment to access the telehealth vendor's technological platform.

Not Eligible for Payment

The terms telemedicine and telehealth are often used interchangeably. However, telehealth is a broader term which can include the provision of remote access to services such as medical information, health assessments, general self-care instructions, and transmission of still images. The broader services considered telehealth are not eligible for payment, except to the extent that store-and-forward services will be reimbursed pursuant to the requirements under Vermont law.

Except as may be permitted in emergency situations, services rendered via audio-only telephone, e-mail, Skype, FaceTime, or facsimile are not eligible for payment.

Installation or maintenance of any telecommunication devices or systems is not eligible for payment.

Telehealth transmission (HCPCS Code: T1014) is not eligible for payment because it is considered inclusive to the services being provided and should not be separately reported and billed.

A distant site health care provider's services are not eligible for payment if that provider has insufficient information to render an opinion.[15]

Eligible Services

BCBSVT covers Telemedicine services in accordance with 8 V.S.A. §4100k and reimburses for covered services as outlined in the "Policy" section above. It is important to verify the member's benefits prior to providing the service. The member is financially responsible for services beyond the benefit provided for eligible services.

Benefit Determination Guidance

Payment for Telemedicine services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

[14] See footnote 10.
[15] 8 V.S.A. §4100k(g) ("Nothing in this section shall be construed to require a health insurance plan to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.")

Eligible Telemedicine services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Provider Billing Guidelines and Documentation

A. Synchronous Services

See the current version of the AMA CPT® Manual, Appendix P (CPT® Codes That May be used for Synchronous Telemedicine Services), which contains a summary of codes that may be used for reporting synchronous (real-time) telemedicine services when appended by modifier -95; the procedures on this list involve electronic communication using interactive communications equipment that includes, at a minimum, audio and video. The coding table provided as Attachment 1 to this policy provides a list of services BCBSVT currently provides reimbursement for when billed using telemedicine.

B. Asynchronous Services (Store-and Forward)

See the Policy section, above, as well as Attachment 1 to this policy.

C. Claim Submission and Documentation Guidelines

- Claims for services rendered via telemedicine or store-and forward means are only accepted on the CMS-1500 (or HIPAA compliant 837P) format for professional claims.
- Claims for services rendered via telemedicine or store-and-forward means must be billed with place of service (POS) 02 (telehealth)

- For services provided via synchronous means:
  - Providers at the distant site must submit the appropriate CPT®/HCPCS codes (see CPT® Manual, Appendix P) if the provider is contracted to submit claims to BCBSVT directly. If the provider is not contracted to submit claims to BCBSVT directly, the provider should submit the claims to the local Blue Plan (where the provider is located at the time of service).
  - Modifier -95 must be appended to all CPT-4 codes, and modifier -GT must be appended to all HCPCS Level II codes, in the first modifier position.
  - The provider at the distant site must obtain consent from the patient prior to the service being rendered via telemedicine; if consent is not obtained, the services are subject to denial by BCBSVT.
  - The provider at the distant site must develop a process for obtaining co-payments and deductibles, where applicable.
- Plan-contracted telehealth vendors must:
  - submit claims according to the terms of the vendor's contract with Plan,
  - obtain consent from the patient prior to the service being rendered via telemedicine
  - the distant site provider must develop a process for obtaining co-payments and deductibles where applicable
- For services provided via asynchronous (store and forward) means:
  - Providers at the distant site must submit the appropriate CPT®/HCPCS codes if the provider is contracted to submit claims to BCBSVT directly. If the provider is not contracted to submit claims to BCBSVT directly, the provider should submit the claims to the local Blue Plan (where the provider is located at the time of service).
  - The provider at the originating site must obtain consent from the patient prior to the service being rendered via store-and-forward means; if consent is not obtained, the services are subject to denial by BCBSVT.
  - The provider receiving the information via store-and-forward means must develop a process for obtaining co-payments and deductibles where applicable.
- Originating sites should NOT submit claims unless:
  - The services are for treatment of substance use disorder and
  - The providers at the originating site and the distant site are not employed by the same entity and
  - The originating site facility fee is billed using HCPCS Q3014 on the CMS-1500 (or HIPAA compliant 837P) format for professional claims or UB (HIPAA compliant 837I) format for institutional claims (for institutional claims, the HCPCS code must be billed in conjunction with revenue code 0780 (telemedicine general classification).
- Providers should be sure to document any concerns that may arise as a result of providing the service via telemedicine versus in-person. For example, for certain physical therapy services provided via telemedicine that involve members with balance issues, the provider should be sure to document how that risk was addressed (e.g., by having another person present with the patient for the visit)

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate

payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at http://www.bcbsvt.com/provider-home for the latest news and communications.

Other Information

Eligible Providers

This policy applies to qualified health care professionals practicing within the scope of their licenses.

Audit Information:

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Legislative Guidelines

8 V.S.A. §4100k (including the version that appears in Vermont House Bill 723 (2020))
18 V.S.A. §9361

Related Policies

BCBSVT Temporary/Emergency Payment Policy: Telephone-Only Services
BCBSVT Temporary/Emergency Payment Policy: Telephone Triage
Vermont Board of Medical Practice, Policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (adopted May 6, 2015)

Policy Implementation/Update Information

This policy replaces the policy effective 10/1/17.

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Approved by **Date Approved:__4/3/2020_____**

Joshua Plavin, MD, MPH, MBA, Vice President & Chief Medical Officer

Dawn Schneiderman, Vice President, Chief Operating Officer

Attachment 1

Coding Table

Please Note: *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	90791	Psychiatric diagnostic evaluation	Per CPT® Appendix P
CPT®	90792	Psychiatric diagnostic evaluation with medical services	Per CPT® Appendix P
CPT®	90832	Psychotherapy, 30 minutes with patient.	Per CPT® Appendix P
CPT®	+90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	Per CPT® Appendix P
CPT®	90834	Psychotherapy, 45 minutes with patient.	Per CPT® Appendix P
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)	Per CPT® Appendix P
CPT®	90837	Psychotherapy, 60 minutes with patient.	Per CPT® Appendix P
CPT®	+90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the primary procedure)	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	90846	Family psychotherapy (without the patient present), 50 minutes	Per CPT® Appendix P
CPT®	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	Per CPT® Appendix P
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)	Per CPT® Appendix P
CPT®	90951	End-stage renal disease (ESRD) related services monthly, for patient younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to face visits by a physician or other qualified health care professional per month	Per CPT® Appendix P
CPT®	90952	End-stage renal disease (ESRD) related services monthly, for patient younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month	Per CPT® Appendix P
CPT®	90954	End-Stage renal disease (ESRD) related services monthly, for	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	
CPT®	90955	End-Stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month	Per CPT® Appendix P
CPT®	90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	Per CPT® Appendix P
CPT®	90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition,	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month	
CPT®	90960	End-stage renal disease (ESRD) related services monthly for patient 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	Per CPT® Appendix P
CPT®	90961	End-stage renal disease (ESRD) related services monthly for patient 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month	Per CPT® Appendix P
CPT®	92227	Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral	Per CPT® Appendix P
CPT®	92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	Per CPT® Appendix P
CPT®	93228	External mobile cardiovascular telemetry with electrocardiographic recording,	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	
CPT®	93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	Per CPT® Appendix P
CPT®	93268	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional	
CPT®	93270	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)	Per CPT® Appendix P
CPT®	93271	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis	Per CPT® Appendix P
CPT®	93272	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family	Per CPT® Appendix P
CPT®	96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	Per CPT® Appendix P
CPT®	97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	No prior approval needed but BCBSVT encourages assessments to be performed in person when possible. Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval guidelines.
CPT®	97152	Behavior identification-supporting assessment,	- Refer to Corporate Medical Policy Applied Behavioral

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes	Analysis (ABA) for any prior approval requirements
CPT®	97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval requirements
CPT®	97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval requirements
CPT®	97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	These services should be delivered in person when possible. Telemedicine visits will apply to therapy visit limits.
CPT®	97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	These services should be delivered in person when possible. Telemedicine visits will apply to therapy visit limits.

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	These services should be delivered in person when possible. Telemedicine visits will apply to therapy visit limits.
CPT®	97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	These services should be delivered in person when possible. Telemedicine visits will apply to therapy visit limits.
CPT®	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	Per CPT® Appendix P
CPT®	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	Per CPT® Appendix P
CPT®	97804	Medical nutrition therapy; group (2 or more individual (s)), each 30 minutes	Per CPT® Appendix P
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	Per CPT® Appendix P
CPT®	98961	Education and training for patient self-management by a	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		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	
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	Per CPT® Appendix P
CPT®	99201	Office or other outpatient visit for the evaluation and management of a new patient. Usually, the presenting problems(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	Per CPT® Appendix P
CPT®	99202	Office or other outpatient visit for the evaluation and management of a new patient. Usually, the presenting problems(s) are low to moderate Typically, 20 minutes are spent face-to-face with the patient and/or family.	Per CPT® Appendix P
CPT®	99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually, the presenting problems(s) are moderate severity. Typically, 30 minutes	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		are spent face-to-face with the patient and/or family.	
CPT®	99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Per CPT® Appendix P
CPT®	99205	Office or other outpatient visit for the evaluation and management of a new patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family's needs.	Per CPT® Appendix P
CPT®	99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	Per CPT® Appendix P
CPT®	99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		minutes are spent face-to-face with the patient and/or family.	
CPT®	99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	Per CPT® Appendix P
CPT®	99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and /or family.	Per CPT® Appendix P
CPT®	99231	Subsequent hospital care, per day, for the evaluation and management of a patient. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	Per CPT® Appendix P
CPT®	99232	Subsequent hospital care, per day, for the evaluation and management of a patient. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		bedside and on the patient's hospital floor or unit.	
CPT®	99233	Subsequent hospital care, per day, for the evaluation and management of a patient. Usually, the patient is unstable or has developed a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	Per CPT® Appendix P
CPT®	99241	Office consultation for a new or established patient. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.	Per CPT® Appendix P
CPT®	99242	Office consultation for a new or established patient. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Per CPT® Appendix P
CPT®	99243	Office consultation for a new or established patient. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	Per CPT® Appendix P
CPT®	99244	Office consultation for a new or established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		face-to-face with the patient and/or family.	
CPT®	99245	Office consultation for a new or established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.	Per CPT® Appendix P
CPT®	99251	Inpatient consultation for a new or established patient. Usually, the presenting problem(s) are self-limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.	Per CPT® Appendix P
CPT®	99252	Inpatient consultation for a new or established patient. Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.	Per CPT® Appendix P
CPT®	99253	Inpatient consultation for a new or established patient Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.	Per CPT® Appendix P
CPT®	99254	Inpatient consultation for a new or established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		at the bedside and on the patient's hospital floor or unit.	
CPT®	99255	Inpatient consultation for a new or established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.	Per CPT® Appendix P
CPT®	99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.	Per CPT® Appendix P
CPT®	99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.	Per CPT® Appendix P
CPT®	99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		are spent at the bedside and on the patient's facility floor or unit.	
CPT®	99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	Per CPT® Appendix P
CPT®	+99354	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)	Per CPT® Appendix P
CPT®	+99355	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	Per CPT® Appendix P
CPT®	99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	Per CPT® Appendix P
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	Per CPT® Appendix P
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	Per CPT® Appendix P
CPT®	99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	Per CPT® Appendix P
CPT®	99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician,	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	
CPT®	99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	Per CPT® Appendix P
CPT®	99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	Per CPT® Appendix P
CPT®	99495	Transitional Care Management Services with the following required elements:	Per CPT® Appendix P

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		*****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	
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	Per CPT® Appendix P
CPT®	0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initialed data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	
CPT®	0379T	Visual field assessment, with concurrent real time data	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		analysis and accessible data storage with patient initialed data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	
Revenue Code	0780	Facility charges related to the use of telemedicine services. General Classification Telemedicine	
CDT	D9995	teledentistry - synchronous; real-time encounter; Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.	Refer to Corporate Medical Dental Policy
CDT	D9996	teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review; Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.	Refer to Corporate Medical Dental Policy
HCPCS	G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth	BCBSVT does not allow G Codes (Medicare/CMS required codes). However if the member in question has Medicare Primary the code is eligible for benefit. You may open any denied/rejected claims for review –

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
			Follow section "Medicare Required Coding" in the Medicare Crossover Claim Issues DP
HCPCS	G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth	BCBSVT does not allow G Codes (Medicare/CMS required codes). However if the member in question has Medicare Primary the code is eligible for benefit. You may open any denied/rejected claims for review – Follow section "Medicare Required Coding" in the Medicare Crossover Claim Issues DP
HCPCS	G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth	BCBSVT does not allow G Codes (Medicare/CMS required codes). However if the member in question has Medicare Primary the code is eligible for benefit. You may open any denied/rejected claims for review – Follow section "Medicare Required Coding" in the Medicare Crossover Claim Issues DP
HCPCS	G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth	BCBSVT does not allow G Codes (Medicare/CMS required codes). However if the member in question has Medicare Primary the code is eligible for benefit. You may open any denied/rejected claims for review – Follow section "Medicare Required Coding" in the Medicare Crossover Claim Issues DP
HCPCS	G0426	Telehealth consultation, emergency department or initial	BCBSVT does not allow G Codes (these are Medicare/CMS required codes). If

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		inpatient, typically 50 minutes communicating with the patient via telehealth	the member has Medicare Primary the code is eligible for benefit. You may open any denied/rejected claims for review –Follow section "Medicare Required Coding" in the Medicare Crossover Claim Issues DP
HCPCS	G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth	BCBSVT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit. You may open any denied/rejected claims for review –Follow section "Medicare Required Coding" in the Medicare Crossover Claim Issues DP
HCPCS	Q3014	Telehealth origination site facility fee	Use with Revenue Code 0780
MODIFIER	-95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	Append to Level I CPT® Codes
MODIFIER	-GQ	Via asynchronous telecommunications system	Refer to Telemedicine Payment policy guidelines
MODIFIER	-GT	Via interactive audio and video telecommunications systems	Append to HCPCS Via Level II Codes
The following codes will be considered Non-Covered			
CPT®	90845	Psychoanalysis	Non-Covered
HCPCS	S9110	Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software;	Non-Covered

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		maintenance; patient education and support; per month	
HCPCS	T1014	Telehealth transmission, per minute, professional services bill separately	Non-Covered

[1]Current Procedural Terminology CPT® codes and descriptions are the property of the American Medical Association.
[2]Healthcare Common Procedure Coding System (HCPCS) code set and descriptions are the property of CMS.