



BlueCross BlueShield of Vermont

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TEMPORARY/EMERGENCY POLICY: INTENSIVE OUTPATIENT THERAPY SERVICES AND PSYCHOTHERAPY (CRISIS AND GROUP) SERVICES BY TELEMEDICINE OR TELEPHONE Corporate Payment Policy

Effective March 13, 2020 (retroactive)

File Name: BCBSVT Corporate Payment Policy 28 (Temporary/Emergency): Intensive Outpatient Therapy Services and Psychotherapy (Crisis and Group) Services by Telemedicine and Telephone

Policy No.: CPP_28

Last Review: March 2020

Next Review: 60 days after implementation

Effective Date: March 13, 2020 (retroactive)

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

This payment policy is implemented in the context of the coronavirus pandemic and in an effort to improve social distancing.

BCBSVT’s Corporate Payment Policy on Telemedicine continues to apply for the services identified in that policy and rendered via HIPAA-compliant audio/ video means. This policy supplements that existing policy, for intensive outpatient therapy services (IOP) as well as psychotherapy services for crisis and group psychotherapy services delivered via telemedicine or telephone, on a temporary/emergency basis.



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Policy

On a temporary/emergency basis, BCBSVT will pay for intensive outpatient therapy (IOP) services and psychotherapy services for crisis and group psychotherapy services when:

- Services are provided to an existing patient (except for psychotherapy for crisis which may be provided to new OR existing patients),
- Services are rendered via HIPAA-compliant audio/video telemedicine means or by telephone if audio/video telemedicine is not available, and
- When the visit is between a provider and a patient (or parent of a patient under the age of 12)

The Provider is responsible for:

- Obtaining verbal or written consent from the patient or the patient's adult representative for the use of telemedicine to conduct the visit
- Documenting this consent in the patient's medical record
- Advising the patient that the visit will be billed to BCBSVT
- Documenting the visit in accordance with standard requirements, including the requirements set forth in the applicable BCBSVT policies, such as the Medical and Treatment Records Standards policy. These requirements include, but are not limited to the following:
 - Documentation that the patient has been informed about the nature of the service and that it will be billed to BCBSVT as such;
 - Documentation of the member's individualized treatment plan; and
 - Progress notes demonstrating evidence of improvement and/or lack of improvement or regression
- Using telemedicine only for visits that fall within the standard of care and that can be reasonably and safely handled via telemedicine
- Obtaining any prior approval that may be required by the member's benefits.

Not Eligible for Payment

Any services delivered pursuant to the terms of this temporary policy should be appropriate for delivery through telemedicine. Services not appropriate for delivery via telemedicine may not be reimbursed.

Eligible Services

Please see the coding tables provided as Attachment 1 to this policy.

Benefit Determination Guidance

Coverage for services is dependent on 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. However, under this temporary policy, services that are covered under a benefit plan will be covered as if they were delivered in the office.



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Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible. Member cost sharing under this policy will be the same cost sharing that would apply had the services been delivered in-person.

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. Intensive outpatient therapy services

IOP services should be billed in the same way they would have been billed had the services been provided in person. In other words, providers should NOT append the telemedicine modifiers (-95 or -GT) to the CPT® or HCPCS codes associated with IOP services, and providers should NOT utilize place of service 02 for IOP services.

B. Psychotherapy services

For psychotherapy (for crisis services) and group psychotherapy services, providers should append the appropriate telemedicine modifier (-95 for CPT® codes and -GT for HCPCS codes) and bill using place of service 02.

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



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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.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network providers/facilities.

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.

Related Policies/References:

BCBSVT Corporate Payment Policy 03 – Telemedicine

BCBSVT Corporate Payment Policy 24 (Temporary/Emergency) – Telephone-only Services

BCBSVT Corporate Payment Policy 25 (Temporary/Emergency) – Telephone Triage

BCBSVT Medical and Treatment Record Standards Policy

Reference: American Medical Association. (2020). *CPT®: Current Procedural Terminology (Professional)*. Chicago IL: American Medical Association.

Policy Implementation/Update Information

This policy is implemented on an emergency/temporary basis retroactive to March 13, 2020. The policy will be reviewed on or before May 29, 2020.



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Approved by

Date Approved: 3/25/2020

A handwritten signature in black ink, appearing to read "Josh Plavin MD, MPH".

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

A handwritten signature in black ink, appearing to read "Dawn Schneiderman".

Dawn Schneiderman, Vice President, Chief Operating Officer



Attachment 1: Coding Tables

Table 1: Intensive Outpatient Therapy Codes

The following will be considered as Medically Necessary when applicable criteria have been met. Providers should bill IOP codes according to the provider’s contract with BCBSVT.

Code	Description	Instructions
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	Provider should bill the code(s) listed in the provider’s contract with BCBSVT as if the services were provided in person.
S9480	Intensive outpatient psychiatric services, per diem	Provider should bill the code(s) listed in the provider’s contract with BCBSVT as if the services were provided in person.
0905	Behavioral Health Treatments/Services – Intensive Outpatient Services - Psychiatric	Provider should bill the code(s) listed in the provider’s contract with BCBSVT as if the services were provided in person.
0906	Behavioral Health Treatments/Services - Intensive Outpatient Services-Chemical Dependency	Provider should bill the code(s) listed in the provider’s contract with BCBSVT as if the services were provided in person.

Table 2: Psychotherapy Codes

The following will be considered as Medically Necessary when applicable criteria have been met. Providers should bill IOP codes according to the provider’s contract with BCBSVT.

Code	Description	Instructions
90839	Psychotherapy for crisis; first 60 minutes	Append the -95 modifier for services delivered via telemedicine. Bill place of service 02.



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90840	Psychotherapy for crisis; each additional 30 minutes; list separately in addition to code for primary service	Append the -95 modifier for services delivered via telemedicine. Bill place of service 02.
90849	Multiple-family group psychotherapy	Append the -95 modifier for services delivered via telemedicine. Bill place of service 02.
90853	Group psychotherapy (other than of a multiple-family group)	Append the -95 modifier for services delivered via telemedicine. Bill place of service 02.