BlueCross BlueShield of Vermont
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TEMPORARY/EMERGENCY POLICY: TELEPHONE-ONLY SERVICES Corporate Payment Policy Effective 03.17.2020

File Name: CPP_24 BCBSVT Temporary/Emergency Payment Policy: Telephone-only Services
Policy No.: CPP_24
Last Review: March 2020
Next Review: 60 days after implementation
Effective Date: March 17, 2020

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 will be implemented in the setting of active coronavirus infection with a health service area (HSA) and in an effort to improve social distancing when:

- The spread of the virus has reached a point where BCBSVT wishes to implement the policy for the benefit of our members OR
- BCBSVT is directed, by government action to pay for these telephone-only and store and forward services.

BCBSVT's Payment Policy on Telemedicine continues to apply for services rendered via HIPAA-compliant audio and video means. This policy supplements that existing policy, on a temporary/ emergency basis.

Policy

BCBSVT will pay for telephone calls between a provider and a patient (or parent of a patient for individuals under the age of 12) when:

- The provider believes the patient's needs require an office visit AND
- It is not in the best interest of the patient to be seen in the office due to the coronavirus outbreak AND
- The condition for which the patient is calling can be handled over the phone in a manner consistent with the current standard of care AND
- Video/Audio Telemedicine using HIPAA-compliant equipment is not available

The Provider is responsible for:

- Obtaining verbal or written consent from the patient or the patient's adult representative for the use of the telephone to conduct an "office visit"
- Documenting patient consent in the patient's medical record
- Advising the patient when the visit converts over to an "office visit", that it will be billed to BCBSVT
- Billing the telephone "office visit" with a -95 modifier (for CPT codes) or -GT modifier (for HCPCS codes) so that the use of telemedicine/telephone services may be identified
- Respecting the patient who requests the phone call remain a phone call and not be documented or billed as an office visit
- Documenting the phone call in accordance with standard requirements including the following:
    - Documentation that the patient has been informed this is considered an office visit
    - History of the present illness
    - Review of systems
    - Past medical history, allergies, medications, social history as applicable
    - Any documentation of photographs or other emailed or otherwise obtained information
    - Diagnosis, plan, and medical decision making
- Using telephone calls only for visits that fall within the standard of care and that can be reasonably and safely handled over the telephone
- Billing only E/M codes for services that are appropriate for synchronous telemedicine per Appendix P of the CPT coding manual (a list of codes is also provided as Attachment 1 to this policy)

Not Eligible for Payment

Any services delivered pursuant to the terms of this temporary policy should be appropriate for delivery through telephone-only means. Services that are not appropriate for delivery through telephone-only means may be denied.

Eligible Services

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

Benefit Determination Guidance

Payment for services delivered via telephone-only means 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.

Eligible 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

See the Policy section, above.

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.

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.

Legislative Guidelines

N/A

Related Policies

BCBSVT Corporate Payment Policy 03 - Telemedicine

Policy Implementation/Update Information

This policy is implemented on an emergency/temporary basis effective March 17, 2020. The policy will be reviewed on or before May 15, 2020.

Approved by **Date Approved:** 3/17/2020

3/17/2020

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

3/17/20

Dawn Schneiderman, Vice President, Chief Operating Officer

Attachment 1

Coding Table

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	
CPT®	90792	Psychiatric diagnostic evaluation with medical services	
CPT®	90832	Psychotherapy, 30 minutes with patient.	
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)	
CPT®	90834	Psychotherapy, 45 minutes with patient.	
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)	
CPT®	90837	Psychotherapy, 60 minutes with patient.	
CPT®	+90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the primary procedure)	
CPT®	90846	Family psychotherapy (without the patient present), 50 minutes	
CPT®	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	
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)	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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	
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	
CPT®	90954	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 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	
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	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		visits by a physician or other qualified health care professional per month	
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, 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	
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	
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	
CPT®	92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	
CPT®	93228	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	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		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	
CPT®	93268	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; 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)	
CPT®	93271	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		to 30 days, 24-hour attended monitoring; transmission and analysis	
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	
CPT®	96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family	
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	
CPT®	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	
CPT®	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	
CPT®	97804	Medical nutrition therapy; group (2 or more individual (s)), each 30 minutes	
CPT®	98960	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		with the patient (could include caregiver/family) each 30 minutes; individual patient	
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	
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	
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.	
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.	
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 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	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	
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.	
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.	
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 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.	
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.	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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.	
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.	
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.	
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 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.	
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.	
CPT®	99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient. Usually, the patient is	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		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.	
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 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.	
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)	
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)	

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	
CPT®	99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	
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	
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	
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	
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	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
		*Face-to-face visit, within 7 calendar days of discharge	
Revenue Code	0780	Facility charges related to the use of telemedicine services. General Classification Telemedicine	
The following codes will be considered Non-Covered			
CPT®	90845	Psychoanalysis	Non-Covered
CPT®	0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated 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	Non-Covered
CPT®	0379T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated 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	Non-Covered
HCPCS	S9110	Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month	Non-Covered
HCPCS	T1014	Telehealth transmission, per minute, professional services bill separately	Non-Covered