TEMPORARY/EMERGENCY POLICY CORPORATE PAYMENT POLICY 28:
INTENSIVE OUTPATIENT THERAPY SERVICES AND
PSYCHOTHERAPY (CRISIS AND GROUP) SERVICES
BY TELEMEDICINE OR TELEPHONE

Effective Date: March 13, 2020

Description
This payment policy was implemented on a temporary/emergency basis and will be effective through August 31, 2021. The purpose is to remove barriers to Blue Cross and Blue Shield of Vermont (BCBSVT) members receiving care during the COVID-19 pandemic.

BCBSVT reserves the right to implement, modify, and revoke this policy without the contractual sixty (60) day notification for a change in policy that is normally required in provider contracts. This will apply for both the effective date, due to the urgent and emergent nature of the pandemic, as well as changes to and for withdrawal of the policy. Notice of changes to the policy will be communicated to providers with a notice on BCBSVT’s provider website.

BCBSVT’s Corporate Payment Policy 03 (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.

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 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:
  o Documentation that the patient has been informed about the nature of the service and that it will be billed to BCBSVT as such;
  o Documentation of the member’s individualized treatment plan; and
  o 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
• To the extent any of the individuals providing services are working remotely (i.e., at home), those individuals should take precautions to protect the privacy of protected health information.

**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.

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 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

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 takes precedence.

Policy Implementation/Update Information

This policy was originally implemented on an emergency/temporary basis effective March 13, 2020, and it will continue to be reviewed at regular intervals.

The April 2020 update made minor changes to the policy language.

The August 2020 update extended the end date for the policy.

The November 2020 update extends the end date for the policy.

The June 2021 update clarifies the policy ends August 31, 2021
Joshua Plavin, MD, MPH, MBA, Vice President & Chief Medical Officer

Dawn Schneiderman, Vice President, Chief Operating Officer
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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0015</td>
<td>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</td>
<td>Provider should bill the code(s) listed in the provider’s contract with BCBSVT as if the services were provided in person.</td>
</tr>
<tr>
<td>S9480</td>
<td>Intensive outpatient psychiatric services, per diem</td>
<td>Provider should bill the code(s) listed in the provider’s contract with BCBSVT as if the services were provided in person.</td>
</tr>
<tr>
<td>0905</td>
<td>Behavioral Health Treatments/Services – Intensive Outpatient Services - Psychiatric</td>
<td>Provider should bill the code(s) listed in the provider’s contract with BCBSVT as if the services were provided in person.</td>
</tr>
<tr>
<td>0906</td>
<td>Behavioral Health Treatments/Services - Intensive Outpatient Services - Chemical Dependency</td>
<td>Provider should bill the code(s) listed in the provider’s contract with BCBSVT as if the services were provided in person.</td>
</tr>
</tbody>
</table>

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.

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<th>Code</th>
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</thead>
<tbody>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
<td>Append the -95 modifier for services delivered via telemedicine. Bill place of service 02.</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes; list separately in addition to code for primary service</td>
<td>Append the -95 modifier for services delivered via telemedicine. Bill place of service 02.</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
<td>Append the -95 modifier for services delivered via telemedicine. Bill place of service 02.</td>
</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
<td>Append the -95 modifier for services delivered via telemedicine. Bill place of service 02.</td>
</tr>
</tbody>
</table>