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Telemedicine and Telehealth
Corporate Medical Policy

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Description/Summary

Telehealth and telemedicine are terms that are frequently used interchangeably. For this policy, Telehealth is an umbrella term used to describe all the possible variations of health care services and health care education using telecommunications. Telehealth allows for health care services such as telemedicine, telemonitoring, store and forward in addition to health care education for patients and professionals and related administrative services.

Synchronous telemedicine, a subset of telehealth, is the use of audio-visual telecommunications technology for real-time medical diagnostic and therapeutic purposes when distance separates the patient and health care provider. Telemedicine may substitute for a face-to-face, hands-on encounter between a patient and the healthcare provider when using the appropriate technology. The use of telecommunications to support a clinical decision can incorporate patient data collected and reviewed immediately. In synchronous telemedicine, services are telecommunicated from an originating site to a distant site when the patient is present and participating in the visit.

Asynchronous telemedicine refers to the use of telecommunications to collect patient data for later review when the patient is no longer available, such as telemonitoring or store and forward.

Vermont law 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.”

"Distant Site" means "the location of the health care provider delivering the services through telemedicine at the time the services are provided."

"Health care facility" is defined by 10 V.S.A §94029(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."

"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."

"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, Pub. L. No. 104-191 to be reviewed at a later date by a health care provider at a distance site who is trained in the relevant specialty. In store and forward, the health care provider at the distant site reviews members 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." Imminent harm is not restricted to services that are committed; it can also apply to services that are omitted. The harm that results does not need to occur within a certain time frame; it may occur on a pathway that can predictably and within reason result in harm to the member. The risk of imminent harm can also be cumulative over time.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

Attachment I – Coding Table

When a service may be considered medically necessary

We consider synchronous telemedicine for medical services to be **medically necessary** when:

- They are provided directly to a patient by an in-network health care provider; **AND**
- Are delivered through a live, synchronous, audio and visual, HIPAA compliant communications system; **AND**
- Are delivered as a medical encounter for an individual; **AND** are clinically appropriate for delivery through telemedicine as defined by any applicable laws and rules **AND** as follows:
    - Are for acute conditions that do not require in-person, face-to-face contact

for the standard of care for evaluation and decision making to be achieved; **OR**

- Are for the on-going monitoring of stable long-term chronic conditions that do not require in-person, face-to-face contact for the standard of care for evaluation and decision making to be achieved; **OR**
- Are for pharmacologic management that does not require in-person, face-to-face contact for the standard of care for evaluation and decision making to be achieved;

We consider synchronous telemedicine services for mental health and substance use disorder (MH-SUD) services to be **medically necessary** when:

- They are provided directly to a patient by an in-network health care provider; **AND**
- Are delivered through a live, synchronous, audio and visual, HIPPA compliant communications system; **AND**
- Are delivered as a MH-SUD encounter; **AND**
- Are clinically appropriate for delivery through telemedicine as defined by any applicable laws and rules **AND** as follows:
  - Are for acute conditions that do not require in-person face-to- face contact for the standard of care for mental health evaluation and decision making to be achieved; **OR**
  - Are for the on-going monitoring of stable long-term chronic conditions that do not require in-person face-to-face contact for the standard of care for mental health evaluation and decision making to be achieved; **OR**
  - Are for pharmacologic management that does not require in-person face-to-face contact for the standard of care for mental health evaluation and decision making to be achieved All of the above criteria are met; **OR**
  - The patient has an unstable MH-SUD condition and is being treated in an originating health care site listed below:
    - Hospital outpatient department
    - Inpatient hospital
    - Physician or practitioner office
    - Rural health clinic
    - Critical access hospital
    - Federally Qualified Health Center

NOTE: Any ongoing psychotherapy (that is expected to require more than 5 visits) should be delivered face to face whenever possible.

We consider the use of asynchronous (e.g., store and forward) telecommunication systems to be **medically necessary** when:

- The use of the telecommunication system addresses a care access issue within the designated population; **AND**
- The medical literature on the use of the asynchronous technology has demonstrated favorable impacts on health outcomes for a specific patient population; **AND**

- The telecommunication system is capable of providing clear audio and video communication with a digital camera or digital equipment with attachments designed to capture pertinent clinical findings; **AND**
- The consultant evaluation of asynchronous information may occur at a later time but the documentation of the assessment and the communication back to the patient and/or provider must occur on the same day that the consultant initiated the consult.

When a service is considered not medically necessary

- For synchronous telemedicine: When the identity of the health care provider is unknown to the patient (see Policy Guidelines)
- For asynchronous telemedicine when the identity of the health care provider is unknown either to the patient or to the provider supplying the original file (see Policy Guidelines)
- Any online or telemedicine visit occurring during the post-operative period
- Request for medication refills without documentation of an appropriate provider visit
- Reporting of test results without documentation of an appropriate provider visit
- A visit for the sole provision of educational materials
- Scheduling of appointments and other administrative related issues
- Registration or updating billing information
- Reminders for healthcare related issues

When a service is considered non-covered

Telehealth transmission (T1014) is not eligible for payment because it is considered to be inclusive.

Any online or telemedicine visit resulting in an office visit, urgent care or emergency care encounter on the same day by the same provider, for the same condition is not eligible for payment because it is considered to be inclusive.

When a service is considered a benefit exclusion and therefore not covered

Telemonitoring home care

Services rendered via email, non-HIPAA-compliant platforms (such as Skype, FaceTime), or facsimile are not eligible for payment

Installation or maintenance of any telecommunication devices or systems

When the health care provider is an out-of-network provider and the service has not been prior-authorized for out of network services per the Out-of-Network Services Claim Processing Policy and Procedure Document

Annual or subscription or retainer fees charged by concierge medicine practices.

When a service is considered investigational

Services traditionally offered as hands-on therapy are considered investigational for telemedicine. These include but are not limited to:

- Some elements of
  - Telephysical Therapy
  - Telecardiac Rehabilitation
  - Telespeech Therapy
  - Teleoccupational Therapy
  - Telerespiratory Therapy
  - Telechiropractic Therapy

Policy Guidelines

All pertinent elements of the History, Past Medical History, Physical Exam and Vital Signs, and Assessment and Plan can be met at the same level as an in-office visit, as sufficient to meet the standard for care for that care episode.

Telemedicine may not be used in place of an in-person visit if the consequence of using telemedicine might reasonably result in imminent harm to the member. The care provided must be able to meet the standard of care as defined above.

Non-verbal children, developmentally delayed children and adults, incapacitated adults who cannot easily be evaluated over telemedicine, and children who are not old enough to interact with the provider over an audio-visual telemedicine connection present a special concern for quality and appropriateness of care. For these individuals especially, it is critical to understand the risks and concerns that third-party reporting may present in the clinical evaluation. Therefore, telemedicine should only be utilized if the standard for care (as defined above) can be met for that care episode, taking into account the critical role that an in-person assessment, the physical examination, and vital signs may play in the care of these vulnerable individuals.

A provider using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the provider-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation.

Some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.

The provider-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation that physicians and other qualified health care professionals recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a provider-patient relationship. A provider is discouraged from rendering medical advice and/or care using telemedicine technologies without

    - fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; **AND**
    - disclosing and validating the provider's identity and applicable credential(s); **AND**
- obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies.
- An appropriate provider-patient relationship has not been established when the identity of the provider may be unknown to the patient. Where appropriate, a patient should be able to select an identified provider for telemedicine services and not be assigned to a provider at random.

  For asynchronous provider-to-provider file transactions, the same principles listed above in the provider-patient relationship should apply as well with the obligation applying to both parties to understand and to execute on their obligations and responsibilities with regard to the patient information.

  There is evidence that telemedicine technology can work and can be used beneficially from a clinical and economic standpoint. While there are many promising initiatives underway, there are few mature telemedicine programs and few good scientific evaluations. There is still some need to work collaboratively to identify best practices. Historically, the originating site might include the following: • Hospital outpatient departments • Inpatient hospitals • Physician or practitioner office • Rural health clinic • Critical access hospitals • Federally qualified health centers.

  Mental health services in settings other than a health care facility or office should be limited to stable patients with limited straightforward needs. Patients with acute psychiatric needs may not be candidates for telemedicine. Similarly, patients requiring ongoing psychotherapy beyond crisis resolution are not typically good candidates for telemedicine, at least not without an originating site. Any ongoing psychotherapy (persistent or chronic conditions expected to require more than 2-3 months of therapy) should be delivered face-to-face whenever possible.

  A secured electronic channel must include and support all of the following for audio/ visual encounters:

    - The electronic channel must be secure, with provisions for privacy and security, including encryption, in accordance with HIPAA guidelines.
    - A mechanism must be in place to authenticate the identity of correspondent(s) in electronic communication and to ensure that recipients of information are authorized to receive it.
    - The patient's informed consent to participate in the consultation must be obtained, including discussing appropriate expectations, disclaimers and service terms, and any fees that may be imposed. Expectations for appropriate use must be specified as part of the consent process including use of specific written guidelines and protocols, avoiding emergency use, heightened consideration of use

for highly sensitive medical topics relevant to privacy issues per 18 VSA 9361.
- The name and patient identification number is contained in the body of the message, when applicable.
- A standard block of text is contained in the provider's response that contains the physician or other qualified health care professional's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies, when applicable.
- A record of online communications descriptive of the online visit should be made available to the patient if requested.

Regulatory status

National Regulations:

- 42 C.F.R. § 414.65 (Payment for Telehealth Services).
- CMS Manual System, List of Medicare Telehealth Services, https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth
- CMS telehealth guidelines indicated as in Appendix A Vermont Regulations:
- 8 V.S.A. § 4100k (as amended by Act 91 (2020))
- 18 V.S.A. § 9361 (as amended by Act 91 (2020))

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

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

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required and benefits are subject to all terms, limitations and

conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

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.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

12/2020	New policy
07/2021	Coding table reviewed added codes: 09839, 90840, 97110, 97112,97116, 97151, 97152, 97156, 97157, 97530, 97535, G2010, G2025. Added-GQ modifier. Updated table with * to denote code is NOT in 'Appendix P' of CPT®.
08/2021	Policy reviewed codes 90849 &90853 added to coding table.
12/2021	Adaptive Maintenance Review Effective 01/01/2022: Removed the (*) and added the codes to the coding table: 90839, 90840, 90963, 90964, 90965, 90966, 97110, 97112, 97116,97530, 97535. Added the following codes to the coding table: 90785, 90967, 90968, 90969, 90970, 96160, 96161, 97161, 97162, 97165, 97166, 97530, 97535, 97750, ,97755, 97760, 97761, 99211, 99356, 99357, 99497, 99498.
12/2021	External input received. Deleted reference to only individual services under MHSUD medical necessity as some MHSUD group services are now allowed within the policies. Coding table updated to add some codes appropriate for telehealth within speech therapy services. Added codes 92507*, 92521*, 92522*, 92523*, 92524* to coding table. Effective 04/01/2022

02/2022	Added codes: 0362T*, 96110*, 96127*, 97153*, 97154*, 97155*, 97158*, 97164* Effective 04/01/2022.
08/2022	Added codes 99605*, 99606* & +99607* to coding table with instructions.
12/2022	Adaptive Maintenance Effective 01/01/2023: Removed * from the following codes: 92507, 92508, 92521, 92522, 92523, 92524. Deleted the following codes: 99241, 99251, 99354, 99355, 99356, 99357. Added the following codes: 92526, 92601, 92602, 92603, 92604, 96105, 96125, 99418. Revised the following codes: 92508, 99231, 99232, 99233, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99307, 99308, 99309, 99310, 99417, 99446, 99447, 99448, 99449, 99495, 99496. Added the following new code: 99418
01/2023	Revised Adaptive Maintenance Effective 01/01/2023: Additional codes added to coding table effective 01/01/2023: 96121, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170 (Non-covered), 96171(Non-Covered).
03/2023	Effective 05/01/2023: Added codes H0015, H0035, S0201, S9443, S9480 to coding table as eligible from CPP_34 being archived.
12/2023	Adaptive Maintenance Effective 01/01/2024: Added Codes: G0466, G0467, G0469, G0470. Added instructions to coding table for code G2010. Revised code descriptors: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99231, 99232, 99233. Clarification of Out-of-Network Services Claim Processing Policy and Procedure Document Name change.
02/2024	Code G2211 added as eligible effective 01/01/2024 per coding table instructions.
11/2024	Policy reviewed. Grammatical and formatting changes for clarity and consistency. Addition of existing Certificate Benefit Exclusion language to policy: “Annual or subscription or retainer fees charged by concierge medicine practices.” Revised Coding table Added codes: 96041, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007. Deleted code 96040. Updated code G2211(refer to Corporate Payment Policy CPP_39) payment policy effective 1/01/2025), Removed Codes:99212, 99213, 99214, 99215, 99202, 99203, 99204, 99205. Removed -GQ & -GT Modifiers.
01/2025	The Telemedicine and Telehealth Corporate Medical Policy was posted incorrectly on the website for the effective date 01/01/2025. The Coding Table had codes that were considered eligible located in two sections of the medical policy causing confusion - The error has been corrected within the policy table: Codes 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, are considered eligible and have been removed from the non-covered section of the table and code 98016 was removed from the coding table policy effective 01/01/2025.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors

Tom Weigel, MD, MBA
Vice President and Chief Medical Officer

Tammaji P. Kulkarni, MD
Senior Medical Director

Attachment I
Coding Table

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	0362T*	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	Requires Prior Authorization
CPT®	+ 90785	Interactive complexity (List separately in addition to the code for primary procedure)	
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®	90839	Psychotherapy for crisis; first 60 minutes	
CPT®	+90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	
CPT®	90846	Family psychotherapy (without the patient present), 50 minutes	
CPT®	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	
CPT®	90849*	Multiple-family group psychotherapy	
CPT®	90853*	Group psychotherapy (other than of a multiple-family group)	
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)	

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 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®	90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	

CPT®	90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	
CPT®	90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	
CPT®	90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older	
CPT®	90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	
CPT®	90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age	
CPT®	90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age	
CPT®	90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	
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®	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	
CPT®	92521	Evaluation of speech fluency (eg, stuttering, cluttering)	
CPT®	92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	
CPT®	92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	
CPT®	92524	Behavioral and qualitative analysis of voice and resonance	
CPT®	92526	Treatment of swallowing dysfunction and/or oral function for feeding	
CPT®	92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	
CPT®	92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	
CPT®	92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	
CPT®	92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	

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 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 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®	96041	Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter	
CPT®	96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	

CPT®	96110*	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	
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®	+96121	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; each additional hour (List separately in addition to code for primary procedure)	
CPT®	96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	

CPT®	96127*	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	
CPT®	96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	
CPT®	96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	
CPT®	+96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	
CPT®	96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	
CPT®	96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument	
CPT®	96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	
CPT®	+96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	

CPT®	96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	
CPT®	+96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	
CPT®	97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	
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	
CPT®	97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	
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	

CPT®	97152*	Behavior identification-supporting assessment, 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	Requires Prior Authorization
CPT®	97153*	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes	Requires Prior Authorization
CPT®	97154*	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes	Requires Prior Authorization
CPT®	97155*	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	Requires Prior Authorization
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	Requires Prior Authorization
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	Requires Prior Authorization

CPT®	97158*	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes	Requires Prior Authorization
CPT®	97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	

CPT®	97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	
CPT®	97164*	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.	

CPT®	97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.	

CPT®	97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.	
CPT®	97530	Therapeutic activities, direct (one-on- one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	

CPT®	97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	
CPT®	97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	
CPT®	97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minute	
CPT®	97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	
CPT®	97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	
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®	98000*	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	
CPT®	98001*	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	
CPT®	98002*	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	
CPT®	98003*	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	

CPT®	98004*	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	
CPT®	98005*	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	
CPT®	98006*	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	
CPT®	98007*	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	

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	
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®	99211	Established Patient- Level 1	
CPT®	99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.	

CPT®	99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	
CPT®	99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.	
CPT®	99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	
CPT®	99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	

CPT®	99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	
CPT®	99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.	
CPT®	99252	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	
CPT®	99253	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	

CPT®	99254	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	
CPT®	99255	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.	
CPT®	99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	
CPT®	99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	

CPT®	99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	
CPT®	99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	
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®	+99417	Prolonged outpatient evaluation and management service(s) time of the primary service which when the primary service level has been selected using total time, on the date of the primary service each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)	
CPT®	99418	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact	
CPT®	99446*	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, 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	
CPT®	99447*	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, 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 or other qualified health care professional, 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	
CPT®	99449*	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, 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	
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 At least moderate level of medical decision making 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. High level of medical decision making during the service period Face-to-face visit, within 7 calendar days of discharge	
CPT®	99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	
CPT®	+99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	
CPT®	99605*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient	Benefits are only eligible when provided by a network enrolled and credentialed Pharmacist.
CPT®	99606*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient	Benefits are only eligible when provided by a network enrolled and credentialed Pharmacist

CPT®	+99607*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service)	Benefits are only eligible when provided by a network enrolled and credentialed Pharmacist
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	
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;	
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 Dental Medical 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 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.

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.
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.
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.
HCPCS	G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes 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.
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.
HCPCS	G0466	Federally qualified health center (FQHC) visit, new patient	BCBSVT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.

HCPCS	G0467	Federally qualified health center (FQHC) visit, established patient	BCBSVT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
HCPCS	G0469	Federally qualified health center (FQHC) visit, mental health, new patient	BCBSVT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
HCPCS	G0470	Federally qualified health center (FQHC) visit, mental health, established patient	BCBSVT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
HCPCS	G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers 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.
HCPCS	G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicatingwith the patient and providers 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.
HCPCS	G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	BCBSVT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.

HCPCS	G2025	Payment for a telehealth distant site service furnished by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) only	BCBSVT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit
HCPCS	+ G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add- on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	Refer to Corporate Payment Policy CPP_39 for additional information.
HCPCS	G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report g2212 on the same date of service as 99358, 99359, 99415, 99416). (do not report g2212 for any time unit less than 15 minutes)	BCBSVT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
HCPCS	G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment	BCBSVT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.

HCPCS	G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	BCBSVT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
HCPCS	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	
HCPCS	H0035	Mental health partial hospitalization, treatment, less than 24 hours	
HCPCS	S0201	Partial hospitalization services, less than 24 hours, per diem	
HCPCS	S9443	Lactation classes, nonphysician provider, per session	
HCPCS	S9480	Intensive outpatient psychiatric services, per diem	
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
The following codes will be considered Non-Covered			
CPT®	90845	Psychoanalysis	Non-Covered
CPT®	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Non-Covered
CPT®	96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	Non-Covered

CPT®	+96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	Non-Covered
HCPCS	G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; **5-10 minutes of clinical discussion**	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

+ Code is an Add-on Code per CPT®

* Code NOT Listed in 'Appendix P' /CPT®