BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

BERLIN HQ
445 INDUSTRIAL LANE
BERLIN, VERMONT 05641

P.O. BOX 186
MONTPELIER
VT 05601-0186

800 247 2583
800 922 8778
802 255 4550

CORPORATE PAYMENT POLICY 03
TELEMEDICINE

Origination: August 2012
Last Review: February 2022
Next Review: April 2023 (or as needed)
Effective Date of Most Recent Updates: April 1, 2022

Description

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

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."[3]

"Distant site" means "the location of the health care provider delivering the services through telemedicine at the time the services are provided."[4]

"Health care facility" is defined by 18 V.S.A. § 9402(6).[5]

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[1] 8 V.S.A. § 4100k(a).
[2] 8 V.S.A. § 4100k(e)(1).
[3] 8 V.S.A. § 4100k(i)(7).
[4] 8 V.S.A. § 4100k(i)(1).
[5] 8 V.S.A. § 4100k(i)(3)(""Health care facility" shall have the same meaning as in 18 V.S.A. §9402."); 18 V.S.A. §9402(6) (""Health care facility" means all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all institutions included in subdivision 9432(8) of this title, except Health Maintenance Organizations."); 18 V.S.A. §9432(8) (listing hospitals, including general hospitals, mental hospitals, chronic disease facilities, birthing centers, maternity hospitals, and psychiatric facilities including any hospital conducted, maintained, or operated by the state of Vermont, or its subdivisions, or a duly authorized agency thereof, as well as nursing homes, home health agencies, outpatient diagnostic or therapy programs, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories, cardiac catheterization laboratories, radiation therapy facilities, or any inpatient or ambulatory surgical, diagnostic, or treatment center.)

"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."[6]

"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."[7]

"Store and forward" means "an asynchronous transmission of medical information, such as one or more video clips, audio clips, still images, x-rays, magnetic resonance imaging scans, electrocardiograms, electroencephalograms, or laboratory results, sent over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 to be reviewed at a later date by a health care provider at a distant site who is trained in the relevant specialty. In store and forward, the health care provider at the distant site reviews the medical information without the patient present in real time and communicates a care plan or treatment recommendation back to the patient or referring provider, or both."[8]

BCBSVT may contract with a telehealth vendor for the provision of telemedicine services to Plan members. Under this arrangement, the telehealth vendor supplies a network of health care providers that Plan members access through the vendor's HIPAA-compliant communications system. The vendor submits claims to BCBSVT directly for services rendered. Note that although Vermont law requires a health insurance plan to provide the same reimbursement rate for services regardless of whether the services was provided through an in-person visit or through telemedicine, this requirement does not apply to services provided pursuant to the health insurance plan's contract with a third-party telemedicine vendor.[9]

Policy

A. Synchronous

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

- Covered by the member's benefit plan;
- Clinically appropriate for delivery through telemedicine, as defined by any applicable laws, rules, or policies; and

[6] 8 V.S.A. § 4100k(i)(4).
[7] 8 V.S.A. § 4100k(i)(5).
[8] 8 V.S.A. § 4100k(i)(6).
[9] 8 V.S.A. § 4100k(a)(2)(B).

- Delivered using live interactive audio and video over a secure connection that complies with the requirements of HIPAA.[10]

The coding table appended as Attachment 1 to this policy outlines the services BCBSVT reimburses for when delivered via telemedicine or store and forward means. A provider must comply with any state or local licensing rules that apply to the delivery of telemedicine services.[11] Plan reserves the right to deny a claim if the provider has not satisfied applicable licensing requirements. In addition, for the treatment of substance use disorder when the originating site is an in-network health care facility, Plan will reimburse both the health care provider at the distant site and the health care facility at the originating site for the services rendered unless the health care providers at both the distant and originating sites are employed by the same entity.[12]

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

B. Asynchronous

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

- If Provider A has a visit with a member (in-person or via synchronous telemedicine), Provider A may bill for the services that Provider A rendered to the member and collect any cost share associated with that visit, even if Provider A also decides to arrange for store-and-forward telemedicine with Provider B regarding the member's care.

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[10] Per section 26(a)(1) of Act 6 (2021), through March 31, 2022, the requirement to use a connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 is waived "if it is not practicable to use such a connection under the circumstances."

[11] Section 4 of the Policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine, adopted by the Vermont Board of Medical Practice on May 6, 2015, available at https://www.healthvermont.gov/sites/default/files/documents/2016/12/BMP_Policies_Vermont%20Telemedicine%20Policy_05062015%20.pdf states: "A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care." Although the policy only explicitly refers to physicians, Vermont law defines "health care provider" in the context of telemedicine, to be a "person, partnership, or corporation, other than a facility or institution, that is licensed, certified, or otherwise authorized by law to provide professional health care services in this State to an individual during that individual's medical care, treatment, or confinement," 8 V.S.A. §4100k(i)(4), which appears to follow a similar policy (that the clinician be licensed where the patient is located). Note, however, that section 17 of Act 6 (2021) has waived license requirements in certain circumstances through March 31, 2022.

[12] 8 V.S.A. §4100k(h).

[13] 18 V.S.A. §9361 requires a provider delivering health care services through telemedicine to obtain and document a patient's oral or written informed consent for the use of telemedicine technology prior to delivering the services to the patient. Note, however, that section 26 of Act 6 (2021) has waived the requirement to obtain and document this consent through March 31, 2022, if "not practicable" under the circumstances.

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

C. Third-party Telehealth Vendor

For telemedicine services delivered to Plan members through a Plan-contracted telehealth vendor, Plan will reimburse the vendor according to the contract between Plan and vendor. The health care services must be covered by the member's benefit plan and clinically appropriate for delivery through telemedicine. The services may be provided to a Plan member located outside of Vermont at the time of service so long as the vendor ensures the rendering provider complies with any applicable local or state licensing rules.[14] The services must be delivered through the use of live interactive audio and video over a secure connection that complies with the requirements of HIPAA. In situations where a Plan member accesses telemedicine services for substance use disorder through a Plan-contracted telehealth vendor while the Plan member is located in an in-network health care facility, Plan will reimburse the health care facility at the originating site only where (1) the telehealth vendor's provider is not employed by the same entity as the health care facility at the originating site, and (2) the health care facility at the originating site facilitated the Plan member's use of the telehealth vendor's services by supplying equipment to access the telehealth vendor's technological platform.

Not Eligible for Payment

The terms telemedicine and telehealth are often used interchangeably. However, telehealth is a broader term which can include the provision of remote access to services such as medical information, health assessments, general self-care instructions, and transmission of still images. The broader services

[14] See footnote 11.

considered telehealth are not eligible for payment, except to the extent that store-and-forward services will be reimbursed pursuant to the requirements under Vermont law.

Except as may be permitted in emergency situations, services rendered via e-mail, Skype, FaceTime, or facsimile are not eligible for payment. Please see BCBSVT's Temporary/Emergency Corporate Payment Policy 24 for more information about reimbursement for services delivered via audio-only telephone.

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

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

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

Eligible Services

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

Benefit Determination Guidance

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

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

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

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form

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

upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

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

Provider Billing Guidelines and Documentation

A. Synchronous Services

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

B. Asynchronous Services (Store-and Forward)

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

C. Claim Submission and Documentation Guidelines

- Claims for services rendered via telemedicine or store-and forward means are only accepted on the CMS-1500 (or HIPAA compliant 837P) format for professional claims. If a provider bills on a UB-04 (or electronic equivalent), the provider must ensure the charge excludes any additional amounts (overhead) for use of the facility. In other words, the amounts a provider collects for services billed on a UB-04 should not exceed the amounts the provider would have collected if the services were billed using a CMS-1500.
- Claims for services rendered via telemedicine or store-and-forward means must be billed with place of service (POS) 02 (telehealth)
- For services provided via synchronous means:
    - Providers at the distant site must submit the appropriate CPT®/HCPCS codes (see CPT® Manual, Appendix P, and Attachment 1 to this Policy) if the provider is contracted to submit claims to BCBSVT directly. If the provider is not contracted to submit claims to

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

Eligible Providers

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

Audit Information:

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

Legislative and Regulatory Guidelines

8 V.S.A. §4100k
18 V.S.A. §9361
Department of Financial Regulation Emergency Rule H-2021-01-E
Vermont Act 6 (2021)

Related Policies

BCBSVT Temporary/Emergency Payment Policy 24: Telephone-Only Services
Vermont Board of Medical Practice, Policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (adopted May 6, 2015)

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 established in 2012.
The policy was updated in 2017.
The policy was updated in March of 2020 to reflect legislative changes and COVID-19 impacts.
The policy was updated in December of 2020 (effective January 1, 2021) with the following changes:

- Deleted 99201
- Revised the descriptors for 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355.

- Added 99417, 99446, 99447, 99448, 99449, 0378T, 0379T, G0508, G0509, D9995, D9996, 90963, 90964, 90965, 90966
- Added G2250, G2252, G2211, and G2212 as eligible with Medicare primary; added G2251 as not eligible.
- Moved the "Document precedence" section
- Updated the references to statutory provisions

The policy was updated effective August 1, 2021, to include references to recent regulatory changes and to add codes G2010, G2025, 90839, 90840, and 97535, as well as modifier -GQ, to Attachment 1.

The policy was updated effective September 1, 2021, to add codes 90849 and 90853.

The policy was updated effective January 1, 2022, to add language about facility-based billing for telemedicine and to make the following updates to the coding table: deleted asterisks for codes now appearing on Appendix P, and added the following codes: 90785, 90967, 90968, 90969, 90970, 96160, 96161, 97161, 97162, 97165, 97166, 97750, 97755, 97760, 97761, 99356, 99357, 99497, 99498.

The policy was updated effective April 1, 2022, to add the following codes: 92507*, 92521*, 92522*, 92523*, 92524*, 0362T*, 96110*, 96127*, 97153*, 97154*, 97155*, 97158*, 97164*.

Approved by **Date Approved: February 2022**

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

Dawn Schneiderman, Vice President, Chief Operating Officer

Attachment 1
Coding Table

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

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

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

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

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

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

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-29 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);	

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

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

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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®	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®	96127*	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	
CPT®	96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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®	97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	These services should be delivered in person when possible. Telemedicine visits apply will apply to therapy visit limits.
CPT®	97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	These services should be delivered in person when possible. Telemedicine visits apply will apply to therapy visit limits.
CPT®	97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	These services should be delivered in person when possible. Telemedicine visits apply will apply to therapy visit limits.
CPT®	97151*	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	No prior approval needed but BCBSVT encourages assessments to be performed in person when possible. Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval guidelines.

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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	Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval guidelines.
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	Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval guidelines
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	Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval guidelines
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	Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval guidelines
CPT®	97156*	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval guidelines.

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	97157*	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval guidelines.
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	Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval guidelines.
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.	

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

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

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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 considerations 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	These services should be delivered in person when possible. Telemedicine visits apply will apply to therapy visit limits.

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT	97535	Self-care/home management training (e.g., 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	These services should be delivered in person when possible. Telemedicine visits will apply to therapy visit limits.
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	
CPT®	97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies)	
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	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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 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®	99202	Office or other outpatient 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 time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	
CPT®	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	
CPT®	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	
CPT®	99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	99212	Office or other outpatient 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 time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	
CPT®	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	
CPT®	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	
CPT®	99231	Subsequent hospital care, per day, for the evaluation and management of a patient. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	
CPT®	99232	Subsequent hospital care, per day, for the evaluation and management of a patient. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.	
CPT®	99233	Subsequent hospital care, per day, for the evaluation and management of a patient. Usually, the patient is unstable or has developed a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	

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.	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	99251	Inpatient consultation for a new or established patient. Usually, the presenting problem(s) are self-limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.	
CPT®	99252	Inpatient consultation for a new or established patient. Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.	
CPT®	99253	Inpatient consultation for a new or established patient Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.	
CPT®	99254	Inpatient consultation for a new or established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.	
CPT®	99255	Inpatient consultation for a new or established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.	

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

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	+99354	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215])	
CPT®	+99355	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	
CPT®	+99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual	
CPT®	+99357	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual	
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	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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 office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	
CPT®	99446*	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	99447*	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	
CPT®	99448*	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	
CPT®	99449*	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	

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

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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®	0362T*		Refer to Corporate Medical Policy Applied Behavior Analysis (ABA) for any prior approval guidelines
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

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

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

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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)	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	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 99354, 99355, 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.

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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	Q3014	Telehealth origination site facility fee	Use with Revenue Code 0780
MODIFIER	-95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	Append to Level I CPT® Codes
MODIFIER	-GQ	Via synchronous telecommunication system	Append to HCPCS Level II Codes
MODIFIER	-GT	Via interactive audio and video telecommunications systems	Append to HCPCS Level II Codes
The following codes will be considered Non-Covered			
CPT®	90845	Psychoanalysis	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

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Description**	**Instructions**
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 not in 'Appendix P' /CPT®