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 24: TELEPHONE-ONLY SERVICES

Creation Date: March 2020
Most Recent Update: March 2022 (Effective April 1, 2022)
Next Review Date: On or before December 31, 2022

Description

This payment policy was originally implemented on a temporary/emergency basis in response to the COVID-19 pandemic. The policy has since been revised in accordance with the Vermont Department of Financial Regulation (DFR) Order in Docket No. 21-026-1 (*In Re: Coding and Reimbursement for Audio-Only Telephone Services Required by Act 6 of 2021*).

BCBSVT reserves the right to implement, modify, and revoke this policy without the contractual sixty-day (60) notification for a change in policy that is normally required in provider contracts. Notice of changes to the policy will be communicated to providers via a notice on BCBSVT's provider website.

BCBSVT's Payment Policy on Telemedicine (CPP_03) continues to apply for services rendered via HIPAA-compliant audio and video means. This policy addresses services that are provided via telephone only.

Policy & Billing and Documentation Guidelines

To the extent any of the individuals accepting patient calls are working remotely, those individuals should take precautions to protect the privacy of protected health information.

BCBSVT will pay for telephone calls between a physician/qualified health care professional and a patient (or parent of a patient for individuals under the age of 12) when:

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

The physician/ qualified health care professional is responsible for:

- Obtaining verbal or written consent from the patient or the patient's adult representative for the use of the telephone to conduct an "office visit"[1]
- Documenting patient consent in the patient's medical record
- Advising the patient that when the visit converts over to an "office visit," it will be billed to BCBSVT
- Billing the visit using one of the following options:
    - Telephone-only evaluation and management code.

Code(s)	Place of Service (POS)	Use -93 Modifier?	Use -V3 or -V4 modifier?
CPT® codes 99441, 99442, or 99443	-99	Optional; not required; informational only	No

OR

    - Codes other than telephone-only E/M.

Code(s)	POS	Use -93 Modifier?	Use -V3 or -V4 modifier?
Codes in Attachment 1, other than CPT® codes 99441, 99442, or 99443	-99	Optional; not required; informational only; if used, do not list in the first modifier position	Use -V3 modifier if: - PCP billing a psychotherapy or pharmacologic management code - PCP billing an E/M code for MHSUD primary diagnosis - MHSUD clinician Use -V4 modifier if none of the criteria above apply.

Claims billed with the -V3 modifier will pay at 100% of the current in-person rate for the service, and claims billed with the -V4 modifier will pay at 75% of the current in-person rate. BCBSVT will audit all claims to ensure the correct modifier is being applied based on the criteria listed above, and BCBSVT will recover any

[1] Note that 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. BCBSVT assumes the same consent is expected to be obtained for services delivered via telephone only. 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.

claims where the appropriate modifier is missing or the incorrect modifier was utilized. The -V3 or -V4 must be listed in the first modifier position.

- Respecting the patient who requests the phone call remain a phone call and not be documented or billed as an office visit
- Documenting the phone call in accordance with standard requirements including the following:
    - Documentation that the patient has been informed this is considered an office visit
    - History of the present illness
    - Review of systems
    - Past medical history, allergies, medications, social history as applicable
    - Any documentation of photographs or other emailed or otherwise obtained information
    - Diagnosis, plan, and medical decision making
    - If the code being billed has a timed component, the time spent with the patient needs to be documented in the medical record.
- Using telephone calls only for visits that fall within the standard of care and that can be reasonably and safely handled over the telephone. The list of codes BCBSVT considers to be appropriate for telephone-only service are listed in Attachment 1 to this policy.

Not Eligible for Payment

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

Eligible Services

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

Benefit Determination Guidance

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

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

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

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

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

Eligible Providers

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

Audit Information:

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

Legislative Guidelines

See Vermont Department of Financial Regulation (DFR) Order in Docket No. 21-026-I (*In Re: Coding and Reimbursement for Audio-Only Telephone Services Required by Act 6 of 2021*)

Related Policies

BCBSVT Corporate Payment Policy 03 - Telemedicine

Document Precedence

The Blue Cross and Blue Shield of Vermont ("BCBSVT") Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member contracts and employer benefit documents, provider contracts, BCBSVT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the Plan's claim editing solution, the Plan's claim editing solution takes precedence.

Policy Implementation/Update Information

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

The August 1, 2020 update makes certain minor language changes, adds information about the telephone-only evaluation and management codes, and extends the end date for the policy.

The December 2020 updates (effective January 1, 2021) extend the end date for the policy, move the policy to new letterhead, update the reference to the DFR Emergency rule, add CPT® code 99417, delete CPT® code 99201, and update the descriptors for CPT® codes 99202-99205 and 99212-99215.

In June of 2020, the policy was updated to reflect an end-date of December 31, 2021.

The October 2021 update (effective January 1, 2022) reflects changes to comply with DFR Order in Docket No. 21-026-I.

The January 2022 update (effective January 1, 2022) clarifies that the -93 modifier may be listed as informational.

The March 2022 update (effective April 1, 2022) (1) adds the following codes: 90785, 90849, 90853, 96110, 96127, 96160, 96161, 97151, 97152, 97153, 97154, 97155, 97156 , 97157, 97158, 99497, 99498; and (2) removes the following codes: 90833,90836, 90838, 908960, 98961, 98962, 99495, 99496; and (3) clarifies when the -V3 and -V4 modifiers should be billed.

Approved by **Update Approved: March 2022**

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

Dawn Schneiderman, Vice President, Chief Operating Officer

Attachment 1
Coding Table

The following codes will be considered as Medically Necessary when delivered via audio-only means when applicable criteria have been met and within the scope of the provider's practice.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	+ 90785	Interactive complexity (List separately in addition to the code for primary procedure)	BCBSVT expects these claims will always be billed with -V3 modifier.
CPT®	90791	Psychiatric diagnostic evaluation	BCBSVT expects these claims will always be billed with -V3 modifier.
CPT®	90792	Psychiatric diagnostic evaluation with medical services	BCBSVT expects these claims will always be billed with -V3 modifier.
CPT®	90832	Psychotherapy, 30 minutes with patient.	BCBSVT expects these claims will always be billed with -V3 modifier.
CPT®	90834	Psychotherapy, 45 minutes with patient.	BCBSVT expects these claims will always be billed with -V3 modifier.
CPT®	90837	Psychotherapy, 60 minutes with patient.	BCBSVT expects these claims will always be billed with -V3 modifier.
CPT®	90846	Family psychotherapy (without the patient present), 50 minutes	BCBSVT expects these claims will always be billed with -V3 modifier.
CPT®	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	BCBSVT expects these claims will always be billed with -V3 modifier.
CPT®	90849	Multiple-family group psychotherapy	BCBSVT expects these claims will always be billed with -V3 modifier.
CPT®	90853	Group psychotherapy (other than of a multiple-family group)	BCBSVT expects these claims will always be billed with -V3 modifier.

The following codes will be considered as Medically Necessary when delivered via audio-only means when applicable criteria have been met and within the scope of the provider's practice.			
Code Type	**Number**	**Description**	**Instructions**
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)	BCBSVT expects these claims will always be billed with -V3 modifier.
CPT®	96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family	BCBSVT expects these claims will be billed with -V4 modifier.
CPT®	96110	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	BCBSVT expects these claims will be billed with -V4 modifier.
CPT®	96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	BCBSVT expects these claims will be billed with -V3 modifier
CPT®	96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	BCBSVT expects these claims will be billed with -V4 modifier.

The following codes will be considered as Medically Necessary when delivered via audio-only means when applicable criteria have been met and within the scope of the provider's practice.			
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	BCBSVT expects these claims will be billed with -V4 modifier.
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	BCBSVT expects these claims will be billed with -V3 modifier.
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	BCBSVT expects these claims will be billed with -V3 modifier. (Requires Prior Approval)

The following codes will be considered as Medically Necessary when delivered via audio-only means when applicable criteria have been met and within the scope of the provider's practice.			
Code Type	**Number**	**Description**	**Instructions**
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	BCBSVT expects these claims will be billed with -V3 modifier. (Requires Prior Approval)
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	BCBSVT expects these claims will be billed with -V3 modifier. (Requires Prior Approval)
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	BCBSVT expects these claims will be billed with -V3 modifier. (Requires Prior Approval)
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	BCBSVT expects these claims will be billed with -V3 modifier. (Requires Prior Approval)

The following codes will be considered as Medically Necessary when delivered via audio-only means when applicable criteria have been met and within the scope of the provider's practice.			
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	BCBSVT expects these claims will be billed with -V3 modifier. (Requires Prior Approval)
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	BCBSVT expects these claims will be billed with -V3 modifier. (Requires Prior Approval)
CPT®	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	BCBSVT expects these claims will be billed with -V4 modifier.
CPT®	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	BCBSVT expects these claims will be billed with -V4 modifier.
CPT®	97804	Medical nutrition therapy; group (2 or more individual (s)), each 30 minutes	BCBSVT expects these claims will be billed with -V4 modifier.
CPT®	99202	New Patient – Level 2	Use -V3 modifier if: - PCP billing an E/M code for MHSUD primary diagnosis
CPT®	99203	New Patient – Level 3	
CPT®	99212	Established Patient – Level 2	

The following codes will be considered as Medically Necessary when delivered via audio-only means when applicable criteria have been met and within the scope of the provider's practice.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	99213	Established Patient – Level 3	- MHSUD clinician Use -V4 modifier if none of the criteria above apply.
CPT®	99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	BCBSVT expects these claims will be billed with -V3.
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; 15–30 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	

The following codes will be considered as Medically Necessary when delivered via audio-only means when applicable criteria have been met and within the scope of the provider's practice.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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; 5–10 minutes of medical discussion	No modifier to be billed.
CPT®	99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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	No modifier to be billed.

The following codes will be considered as Medically Necessary when delivered via audio-only means when applicable criteria have been met and within the scope of the provider's practice.			
Code Type	**Number**	**Description**	**Instructions**
CPT®	99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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; 21–30 minutes of medical discussion	No modifier to be billed.
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	BCBSVT expects these claims will be billed with -V4 modifier.

The following codes will be considered as Medically Necessary when delivered via audio-only means when applicable criteria have been met and within the scope of the provider's practice.			
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)	BCBSVT expects these claims will be billed with -V4 modifier.
MODIFIER	-V3		Apply when (1) PCP billing a psychotherapy or pharmacologic management code OR billing an E/M code for MHSUD primary diagnosis OR (2) MHSUD clinician. List in the first modifier position on the claim form.
MODIFIER	-V4		Apply to services rendered by practitioners with medical specialties (including primary care). List in the first modifier position on the claim form.
MODIFIER	-93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System	Informational Only. Do not list in the first modifier position on the claim form. When required to bill in addition to a payment modifier (e.g., V3 or V4), always list in the second modifier position.