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Origination: August 2012
Last Review: January 17, 2025
Next Review: December 12, 2025
Effective Date: August 01, 2025

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 member 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]

Definitions

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]

[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

"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]

Blue Cross and Blue Shield of Vermont (Blue Cross VT) 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 Blue Cross VT directly for services rendered. Note that although Vermont law requires commercial health insurers to pay for health care services delivered via telemedicine/ telephone (audio only) at the same rate as for the equivalent in-person service, this requirement does not apply to services provided pursuant to the health insurance plan's contract with a third-party telemedicine vendor.[9]

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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.)

[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).

Policy & Guidelines

Policy Statement

Effective with dates of service on or after August 2012, Blue Cross VT will allow payment for telemedicine services as eligible for payment to the extent the services follow the guidelines set forth in the payment policy.

Guidelines

A. Synchronous

Blue Cross VT will pay 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
- 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 Blue Cross VT considers eligible 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]

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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).

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

Blue Cross VT 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.
- 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 Blue Cross VT 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 Blue Cross VT if Provider B is located in Vermont or contracted with Blue Cross VTand is eligible to bill Blue Cross VT 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

[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.

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 using 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 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.

Eligible Services

Blue Cross VT covers telemedicine services in accordance with 8 V.S.A. §4100k and pays 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.

Refer to coding table provided as Attachment 1

Not Eligible

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 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 refer to Blue Cross VT's Corporate Payment Policy CPP_24 for more information outlining payment for services delivered via telephone (audio-only).

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

Telehealth transmission (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

[14] See footnote 11.

insufficient information to render an opinion.[15]

Provider Billing Guidelines and Documentation

A. Synchronous Services

Refer to the current version of the American Medical Association (AMA) Current Procedure Terminology (CPT®) Manual, Appendix P (CPT® Codes That May be used for Synchronous Real-Time Interactive Audio-Video 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 Blue Cross VT currently considers eligible services when billed using telemedicine. Blue Cross VT intends to align its list with the list in Appendix P, however, Blue Cross VT 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 provided when member is not in the home) or POS 10 (telehealth provided in member's home).
- 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 Blue Cross VT directly. If the provider is not contracted to submit claims to Blue Cross VT directly, the provider should submit the claims to the local Blue Plan (where the provider is located at the time of

[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.")

service).
    - Modifier -95 must be appended to all procedure codes in the first modifier position.
    - The provider at the distant site must obtain consent from the member prior to the service being rendered via telemedicine; if consent is not obtained, the services are subject to denial by Blue Cross VT.
    - 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 member 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 Blue Cross VT directly. If the provider is not contracted to submit claims to Blue Cross VT 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 member prior to the service being rendered via store-and-forward means; if consent is not obtained, the services are subject to denial by Blue Cross VT.
    - 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 code: **Q3014** on the CMS-1500 (or HIPAA compliant 837P) format for professional claims or UB-04 (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 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 document how that risk was addressed (e.g., by having another person present with the member for the visit).

Benefit Determination Guidance

Payment for 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 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 (Blue Cross VT 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.

Medicare Primary Policies: Blue Cross VT Payment policies do not apply to any policies where Medicare is primary.

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

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence 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

CPP_24 Telephone-Only Services Payment Policy

Reference

American Medical Association. (2025). *CPT®: Current Procedural Terminology* (Professional). *Appendix P*. Chicago IL: American Medical Association.

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT 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 Blue Cross VT 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 Blue Cross VT 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 Blue Cross VT 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 Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Policy Implementation/Update Information

This policy was originally established in August 2012.

Date of Change	Effective Date	Overview of Change
2017		
March 2020		Reflected legislative changes and COVID-19 impacts.
December 2020	January 1, 2021	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.
August 1, 2021	August 1, 2021	Included references to recent regulatory changes and to add codes G2010, G2025, 90839, 90840, and 97535, as well as modifier -GQ, to Attachment 1.
September 1, 2021	September 1, 2021	Added codes 90849 and 90853.
January 1, 2022	January 1, 2022	Added 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.
April 1, 2022	April 1, 2022	Added the following codes: 92507*, 92521*, 92522*, 92523*, 92524*, 0362T*, 96110*, 96127*, 97153*, 97154*, 97155*, 97158*, 97164*. The policy was also updated to reference place of service 10 (telehealth provided in patient's home).
November 1, 2022	November 1, 2022	Added the following codes: 99605*, 99606* and +99607*.
February 27, 2023	January 1, 2023 (retroactive)	Added: 92508 (non-covered), 92526, 92601, 92602, 92603, 92604, 96105, 96121, 96125, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 99418, 96170 (non-covered), and +96171 (non-covered). Deleted the following services: 99241, 99251, 99354, 99355, 99356, and 99357. Removed the * from these services: 92507, 92508, 92521, 92522, 92523, and 92524. Revised the description of the following codes in Attachment 1 to align with the CPT® description changes for January 1, 2023: 99231, 99232, 99233, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99307, 99308, 99309, 99310, 99417, 99446, 99447, 99448, 99449, 99495, and 99496. Revised the description of HCPCS code G2212. Updated Approval line to be Tom Weigel, MD, Chief Medical Officer.
March 13, 2023	May 1, 2023	Added the following codes: H0015, H0035, S0201, S9443, S9480.

June 19, 2023		Referenced on codes 99307, 99308, 99309 & 99310 that CPP_32 Claim Editing Payment Policy set allowances for these services.
November 8, 2023		Included already existing policy details related to Provider Location and Blue Cross VT contract.
December 14, 2023	January 1, 2024 – due to CPT® and HCPCS January 1, 2024, additions and revisions - adaptive maintenance.	Added codes G0466, G0467, G0469, and G0470. Added instruction to the coding table for G2010. Revised code descriptors: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99231, 99232, 99233, 99308.
December 12, 2024	January 01, 2025	Moved to a new template. Added new coding table. Added codes: 96041, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007. Deleted code 96040. Updated G2211 in coding table. Removed codes: 99212, 99213, 99214, 99215, 99202, 99203, 99204, 99205. Removed -GT Modifier.
January 17, 2025	January 01, 2025	Revised policy to remove code 98016 from coding table, code was added in error. Revised coding table to reflect the following intent of the policy for specific add- on codes: For add on-codes 90833, 90836, 90838 Blue Cross VT REQUIRES primary procedure code (98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007).
August 01, 2025	August 01, 2025	Removed coding table instructions “requires prior approval’ from codes: 0362T, 97152, 97153, 97154, 97155, 97156, 97157, 97158- codes do not require prior approval effective 08/01/2025.

Approved by **Update Approved: 08/01/2025**

Tom Weigel, MD, Chief Medical Officer

Attachment I
Coding Table

Code	Description	Instructions
-95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	Append to Appropriate Codes
-GQ	Via asynchronous telecommunications system	Append to Appropriate Codes
0362T*	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	Append modifier -95
+90785	Interactive complexity (List separately in addition to the code for primary procedure)	Append modifier -95
90791	Psychiatric diagnostic evaluation	Append modifier -95
90792	Psychiatric diagnostic evaluation with medical services	Append modifier -95
90832	Psychotherapy, 30 minutes with patient.	Append modifier -95
+90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	Append modifier -95 For add on-code + 90833 Blue Cross VT REQUIRES primary procedure code (98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007)

Code	Description	Instructions
90834	Psychotherapy, 45 minutes with patient.	Append modifier -95
+90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	Append modifier -95 For add on-code + 90836 Blue Cross VT REQUIRES primary procedure code (98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007)
90837	Psychotherapy, 60 minutes with patient.	Append modifier -95
+90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the primary procedure)	Append modifier -95 For add on-code + 90838 Blue Cross VT REQUIRES primary procedure code (98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007)
90839	Psychotherapy for crisis; first 60 minutes	Append modifier -95
+90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	Append modifier -95
90846	Family psychotherapy (without the patient present), 50 minutes	Append modifier -95
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	Append modifier -95
90849*	Multiple-family group psychotherapy	Append modifier -95
90853*	Group psychotherapy (other than of a multiple-family group)	Append modifier -95
+90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)	Append modifier -95
90951	End-stage renal disease (ESRD) related services monthly, for patient younger than 2 years of age to includemonitoring 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	Append modifier -95

Code	Description	Instructions
90952	End-stage renal disease (ESRD) related services monthly, for patient younger than 2 years of age to includemonitoring 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	Append modifier -95
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	Append modifier -95
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	Append modifier -95
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, andcounseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional permonth	Append modifier -95
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, andcounseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month	Append modifier -95

Code	Description	Instructions
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	Append modifier -95
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	Append modifier -95
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	Append modifier -95
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	Append modifier -95
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	Append modifier -95
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older	Append modifier -95
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	Append modifier -95
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	Append modifier -95

Code	Description	Instructions
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age	Append modifier -95
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	Append modifier -95
92227	Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateralor bilateral	Append modifier -95
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	Append modifier -95
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Append modifier -95
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	Append modifier -95
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	Append modifier -95
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	Append modifier -95
92524	Behavioral and qualitative analysis of voice and resonance	Append modifier -95
92526	Treatment of swallowing dysfunction and/or oral function for feeding	Append modifier -95
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	Append modifier -95
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	Append modifier -95

Code	Description	Instructions
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	Append modifier -95
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	Append modifier -95
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	Append modifier -95
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	Append modifier -95
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	Append modifier -95

Code	Description	Instructions
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)	Append modifier -95
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	Append modifier -95
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	Append modifier -95
96041	Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter	Append modifier -95
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	Append modifier -95
96110*	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	Append modifier -95

Code	Description	Instructions
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	Append modifier -95
+96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)	Append modifier -95
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	Append modifier -95
96127*	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	Append modifier -95
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	Append modifier -95
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	Append modifier -95

Code	Description	Instructions
+96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	Append modifier -95
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	Append modifier -95
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	Append modifier -95
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	Append modifier -95
+96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	Append modifier -95
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	Append modifier -95
+96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	Append modifier -95
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Append modifier -95
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	Append modifier -95

Code	Description	Instructions
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	Append modifier -95
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	Append modifier -95
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	Append modifier -95
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	Append modifier -95
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	Append modifier -95
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	Append modifier -95

Code	Description	Instructions
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	Append modifier -95
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	Append modifier -95
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	Append modifier -95
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.	Append modifier -95
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and	Append modifier -95

Code	Description	Instructions
	measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	
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.	Append modifier -95
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance.	Append modifier -95

Code	Description	Instructions
	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.	
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Append modifier -95
97530	Therapeutic activities, direct (one-on- one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	Append modifier -95

Code	Description	Instructions
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	Append modifier -95
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	Append modifier -95
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minute	Append modifier -95
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	Append modifier -95
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	Append modifier -95
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	Append modifier -95
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to- face with the patient, each 15 minutes	Append modifier -95
97804	Medical nutrition therapy; group (2 or more individual (s), each 30 minutes	Append modifier -95
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	Modifier -95 not required code for audio-video

Code	Description	Instructions
98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	Modifier -95 not required code for audio-video
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	Modifier -95 not required code for audio-video
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	Modifier -95 not required code for audio-video
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	Modifier -95 not required code for audio-video
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	Modifier -95 not required code for audio-video

Code	Description	Instructions
98006	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	Modifier -95 not required code for audio-video
98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	Modifier -95 not required code for audio-video
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	Append modifier -95
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	Append modifier -95
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	Append modifier -95
99211	Established Patient- Level 1	Append modifier -95

Code	Description	Instructions
99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.	Append modifier -95
99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	Append modifier -95
99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.	Append modifier -95
99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	Append modifier -95
99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	Append modifier -95

Code	Description	Instructions
99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	Append modifier -95
99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.	Append modifier -95
99252	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	Append modifier -95
99253	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	Append modifier -95
99254	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	Append modifier -95

Code	Description	Instructions
99255	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.	Append modifier -95
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	Append modifier -95
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	Append modifier -95
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	Append modifier -95
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	Append modifier -95

Code	Description	Instructions
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	Append modifier -95
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	Append modifier -95
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	Append modifier -95
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	Append modifier -95
+ 99417	Prolonged outpatient evaluation and management service(s) time of the primary service which when the primary service level has been selected using total time, on the date of the primary service each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)	Append modifier -95
+ 99418	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)	Append modifier -95

Code	Description	Instructions
99446*	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	Append modifier -95
99447*	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	Append modifier -95
99448*	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	Append modifier -95
99449*	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	Append modifier -95

Code	Description	Instructions
99495	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge At least moderate level of medical decision making during the service period Face-to-face visit, within 14 calendar days of discharge	Append modifier -95
99496	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. High level of medical decision making during the service period Face-to-face visit, within 7 calendar days of discharge	Append modifier -95
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 patient(s), and/or surrogate	Append modifier -95
+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)	Append modifier -95
99605*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient	Benefits are only eligible when provided by a network enrolled and credentialed Pharmacist. Append modifier -95

Code	Description	Instructions
99606*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient	Benefits are only eligible when provided by a network enrolled and credentialed Pharmacist Append modifier -95
+99607*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service)	Benefits are only eligible when provided by a network enrolled and credentialed Pharmacist Append modifier -95
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	Append modifier -95
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;	Append modifier -95
0780	Facility charges related to the use of telemedicine services. General Classification Telemedicine	
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 Append modifier -95
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 Append modifier -95

Code	Description	Instructions
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth	Blue Cross VT does not allow G Codes (Medicare/CMS required codes). However, if the member in question has Medicare Primary the code is eligible for benefit.
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth	Blue Cross VT does not allow G Codes (Medicare/CMS required codes). However, if the member in question has Medicare Primary the code is eligible for benefit.
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth	Blue Cross VT does not allow G Codes (Medicare/CMS required codes). However, if the member in question has Medicare Primary the code is eligible for benefit.
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth	Blue Cross VT does not allow G Codes (Medicare/CMS required codes). However, if the member in question has Medicare Primary the code is eligible for benefit.
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.

Code	Description	Instructions
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
G0466	Federally qualified health center (FQHC) visit, new patient	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
G0467	Federally qualified health center (FQHC) visit, established patient	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
G0469	Federally qualified health center (FQHC) visit, mental health, new patient	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
G0470	Federally qualified health center (FQHC) visit, mental health, established patient	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the

Code	Description	Instructions
		code is eligible for benefit.
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicatingwith the patient and providers via telehealth	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
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	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
G2025	Payment for a telehealth distant site service furnished by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) only	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	Refer to Corporate Payment Policy CPP_39 (Office & Outpatient Evaluation and Management Visit Complexity G2211)
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	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the

Code	Description	Instructions
	physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT® codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99358, 99359, 99415, 99416). (do not report G2212 for any time unit less than 15 minutes)	code is eligible for benefit.
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	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the member has Medicare Primary the code is eligible for benefit.
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	Blue Cross VT does not allow G Codes (these are Medicare/CMS required codes). If the has Medicare Primary the code is eligible for benefit.
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	Append modifier -95
H0035	Mental health partial hospitalization, treatment, less than 24 hours	Append modifier -95
S0201	Partial hospitalization services, less than 24 hours, per diem	Append modifier -95

Code	Description	Instructions
S9443	Lactation classes, nonphysician provider, per session	Append modifier -95
S9480	Intensive outpatient psychiatric services, per diem	Append modifier -95
Q3014	Telehealth origination site facility fee	Use with Revenue Code 0780 Append modifier -95
90845	Psychoanalysis	Non-Covered
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Non-Covered
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	Non-Covered
+96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	Non-Covered
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
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
T1014	Telehealth transmission, per minute, professional services bill separately	Non-Covered

+ Code is an Add-on Code per CPT®

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