-

Origination: March 2020
Last Review: December 12, 2024
Next Review: December 12, 2025
Effective Date: January 1, 2025

Description

Background

This payment policy was originally implemented on a temporary/emergency basis in response to the COVID-19 pandemic). This policy has been revised in accordance with the Vermont Department of Financial Regulation (DFR) Order in Docket No. 23-011-I (Coding and Reimbursement for Audio-Only Telephone Services Required by Act 6 of 2021). It is now being revised again in accordance with Vermont Act 108 effective January 1, 2025.

Policy & Guidelines

Policy Statement

Effective with dates of service on or after January 01, 2025, Blue Cross of Vermont (Blue Cross VT) will pay for health care services delivered by telephone (audio-only) at the same rate as for the equivalent in-person service. Refer to Attachment 1 for eligible codes/services.

Note: Blue Cross VT'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 (audio only)**.

Provider Contracting Eligibility

In general, Blue Cross VT is limited to contracting with providers who provide services while physically located in Vermont or a county contiguous to Vermont. Blue Cross VT may not contract with a provider physically located outside the state of Vermont (or a contiguous county) who is providing services via telephone (audio) only.

Blue Cross VT contracted providers temporarily located outside of the State of Vermont but

within the United States for a period not to exceed six months are allowed to continue to contract with Blue Cross VT and provide eligible services by telemedicine, submitting claims to Blue Cross VT for processing.

If at any point the relocation becomes permanent or the six-month time period is exceeded, the Blue Cross VT contract is terminated and claims for services can no longer be submitted to Blue Cross VT. Claims must be submitted to the Blue Plan the provider is located in when the services are rendered.

Note: Out of Country relocation, even if temporary, will terminate your Blue Cross VT contract.

Eligible Services

Refer to coding table provided as Attachment 1.

Not Eligible for Payment

Any services delivered pursuant to the terms of this policy should be appropriate for delivery through telephone (audio-only) means. Services that are not appropriate for delivery through telephone (audio-only) means are not eligible for reimbursement.

Any telephone (audio-only) services rendered that are not listed on Attachment 1 are not eligible for reimbursement and will be denied as provider liability.

Telephone (audio only) services that are not directly provided by a physician/qualified health care professional are not eligible for reimbursement and are considered provider liability.

Provider Billing Guidelines and Documentation

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

Blue Cross VT will pay for telephone -only services between a physician/qualified health care professional and a member (or parent of a member for individuals under the age of 12) when:

- The physician/qualified health care professional believes the member's needs require an office visit AND
- It is not in the best interest of the member to be seen in the office AND
- The condition for which the member is calling can be handled over the telephone 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 member or the member's adult

representative for the use of the telephone to conduct an “office visit”.
- Documenting member’s consent in the member’s medical record.
- Advising the member that when the visit converts over to an “office visit,” it will be billed to Blue Cross VT.

Blue Cross VT audits all claims to ensure the correct modifier is applied. Blue Cross VT recovers any claims where the appropriate modifier is missing, or the incorrect modifier was utilized.

Respecting the member who requests the telephone call remain a telephone-only call and not be documented or billed as an office visit.

Documentation

Place of Service

Claims for services rendered via telephone -only 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).

Documenting the telephone call in accordance with standard requirements including the following:

- Documentation that the member has been informed this is considered an office visit.
- Documentation explaining why it is not in the best interest of the member to be seen in the office.
- Documentation of history of the present illness.
- Documentation of review of systems.
- Documentation of past medical history, allergies, medications, social history as applicable.
- Documentation of any photographs or other emailed or otherwise obtained information.
- Documentation of diagnosis, medical decision making and plan.
- If the code being billed has a timed component, the time spent with the member needs to be documented in the medical record.
- Documentation of respecting the patient who requests the phone call remain a phone call and not be documented or billed as an office visit.

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 Blue Cross VT considers to be appropriate for telephone-only service are listed in Attachment 1.

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

Refer to Vermont Department of Financial Regulation (DFR) Order in Docket No. 23-011-I (Coding and Reimbursement for Audio-Only Telephone Services Required by Act 6 of 2021)

Sec. 1. 8 V.S.A. § 4100l amended [VT Act 108]

Related Policies

CPP_03 Telemedicine Payment Policy

CPP_39 Office and Outpatient Evaluation and Management Visit Complexity G2211 Payment Policy

References

American Medical Association. (2025). CPT®: Current Procedural Terminology (Professional). Appendix T. 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 implemented on March 13, 2020.

Date of Change	Effective Date	Overview of Change
June 2020		Updated to reflect an end-date of December 31, 2021
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
December 2020	January 1, 2021	Updates 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.
October 2021	January 1, 2022	Update reflects changes to comply with DFR Order in Docket No. 21-026-I.
January 2022	January 1, 2022	Update clarifies that the -93 modifier may be listed as informational.
March 2022	April 1, 2022	Update (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, 98960, 98961, 98962, 99495, 99496; and (3) clarifies when the -V3 and -V4 modifiers should be billed.

Date of Change	Effective Date	Overview of Change
December 6, 2022	January 1, 2023	Update extends the policy through December 31, 2023, to comply with DFR order Docket No. 22-019-I, updates all references to Blue Cross and Blue Shield of Vermont (BCBSVT) to be Blue Cross VT, removes Dr. Plavin signature line and replaces with Dr. Weigel signature line, and add a note to Appendix 1 related to AMA and CMS changes.
February 13, 2023		Update reflects the following (1) removes codes 90849, 90853, 90863, 96127, +97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 99202, 99203, 99212, 99213, 99441, 99442, and 99443 as of May 1, 2023 and (2) adds the following codes from Appendix "T" retroactively to January 1, 2023 – 90833, 90836, 90838, 90839, 90840, 90845, 92507, 92508, 92521, 92522, 92523, 92524, 96116, +96121, 96156, 96158, +96159, 96164, +96165, 96167, +96168, 96170, and +96171.
June 22, 2023		Policy maintenance to remove the references and language for services removed effective May 1, 2023: 90849, 90853, 90863, 96127, +97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 99202, 99203, 99212, 99213, 99441, 99442, and 99443 (per the February 13, 2023, changes noted above).
November 8, 2023		Includes already existing policy details related to Provider Location and Blue Cross VT contract.
November 9, 2023	January 1, 2024	To comply with DFR Docket No. 23-011-I, updates are as follows, added the following codes 90853, 96127, 99441, 99442, 99443, G0108, G0109, G0446, G0447, S9443, T1013.
November 29, 2023	January 1, 2024	Updated modifier table, modified references in the code table.
December 12, 2024	January 1, 2025	Moved to a new template and updated to comply with Vermont Act 108 mandates that commercial health insurers pay for medical services delivered by telephone (audio only) at the same rate as for the equivalent in-person service. Added new coding table. Removed deleted codes 99441, 99442, 99443 from coding table and added new codes 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015. Updated related policy and regulatory guideline sections of policy. Removed place of service (99) and added section to address place of service requirements adding (02) & (10).

Approved by **Update Approved: 12/12/2024**

Tom Weigel, MD, Chief Medical Officer

Attachment 1

Coding Table

The following codes will be considered eligible for benefits for telephone- only services when applicable criteria have been met.		
Code	**Descriptor**	**Instructions**
Modifier -93	Synchronous Telemedicine Services rendered via a Real-Time Interactive Audio-Only Telecommunications System	Append modifier to appropriate services provided by telephone-only **is required.**
Place of Service [02]	Telehealth Provided Other Than Patient's Home	Apply appropriate place of service to claim submitted
Place of Service [10]	Telehealth Provided in Patient's Home	Apply appropriate place of service to claim submitted
90785 (+)*	Interactive complexity (List separately in addition to the code for primary procedure)	Append modifier -93
90791*	Psychiatric diagnostic evaluation	Append modifier -93
90792*	Psychiatric diagnostic evaluation with medical services	Append modifier -93
90832*	Psychotherapy, 30 minutes with patient	Append modifier -93
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 -93

The following codes will be considered eligible for benefits for telephone- only services when applicable criteria have been met.		
Code	**Descriptor**	**Instructions**
90834*	Psychotherapy, 45 minutes with patient	Append modifier -93
90836 (+)*	Psychotherapy, 45 minutes with patient	Append modifier -93
90837*	Psychotherapy, 60 minutes with patient	Append modifier -93
90839 (+)*	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	Append modifier -93
90840 (+)*	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	Append modifier -93
90845*	Psychoanalysis	Non-Covered
90846*	Family psychotherapy (without the patient present), 50 minutes	Append modifier -93
90847*	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	Append modifier -93
92507*	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Append modifier -93
92508*	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Non-Covered
92521*	Evaluation of speech fluency (eg, stuttering, cluttering)	Append modifier -93
92522*	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	Append modifier -93
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 -93
92524*	Behavioral and qualitative analysis of voice and resonance	Append modifier -93

The following codes will be considered eligible for benefits for telephone- only services when applicable criteria have been met.		
Code	**Descriptor**	**Instructions**
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 -93
96110*	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	Append modifier -93
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 -93
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 -93
96156*	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	Append modifier -93
96158*	Health behavior intervention, individual, face-to-face; initial 30 minutes	Append modifier -93
96159 (+)*	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	Append modifier -93

The following codes will be considered eligible for benefits for telephone- only services when applicable criteria have been met.		
Code	**Descriptor**	**Instructions**
96160 (+)*	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	Append modifier -93
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 -93
96164*	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	Append modifier -93
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 -93
96167*	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	Append modifier -93
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 -93
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
97802*	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	Append modifier -93
97803*	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	Append modifier -93
97804*	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes	Append modifier -93

The following codes will be considered eligible for benefits for telephone- only services when applicable criteria have been met.		
Code	**Descriptor**	**Instructions**
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	Modifier -93 not required code for audio-only
98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	Modifier -93 not required code for audio-only
98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	Modifier -93 not required code for audio-only
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	Modifier -93 not required code for audio-only

The following codes will be considered eligible for benefits for telephone- only services when applicable criteria have been met.		
Code	**Descriptor**	**Instructions**
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.	Modifier -93 not required code for audio-only
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded	Modifier -93 not required code for audio-only
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	Modifier -93 not required code for audio-only
98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	Modifier -93 not required code for audio-only
99406*	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	Append modifier -93

The following codes will be considered eligible for benefits for telephone- only services when applicable criteria have been met.		
Code	**Descriptor**	**Instructions**
99407*	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	Append modifier -93
99408*	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	Append modifier -93
99409*	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	Append modifier -93
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	Append modifier -93
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 -93

*Code listed in CPT® Appendix 'T'