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Origination: December 12, 2024
Last Review: December 12, 2024
Next Review: December 12, 2025
Effective Date: May 01, 2025

Description

Provide a policy statement to outline purchase options and billing information for the administration and observation of the drug SPRAVATO®(Esketamine) in a provider office and outpatient setting.

Policy & Guidelines

Policy Statement

Effective with dates of service on or after May 01, 2025 Blue Cross and Blue Shield of Vermont (Blue Cross VT) will consider payment for services associated with SPRAVATO® based on applicable criteria set forth below in this policy.

Requirements

To order SPRAVATO® through a Risk Evaluation and Mitigation Strategy (REMS)-certified specialty pharmacy, contact Vermont Blue Rx to identify the appropriate preferred in-network specialty pharmacy. Refer to the SPRAVATO® REMS website for information about REMS, or Risk Evaluation and Management Strategy.

REMS is a strategy to manage known or potential risks associated with a drug and is required by the U.S. Food and Drug Administration (FDA) to ensure that the benefits of the drug outweigh its risks.

- SPRAVATO® nasal spray CIII is available only through a restricted distribution program called the SPRAVATO® REMS because of the risks of serious adverse outcomes resulting from sedation and dissociation caused by SPRAVATO® administration, and abuse and misuse of SPRAVATO®.

- SPRAVATO® is intended for use only in a certified Healthcare Setting.

- SPRAVATO® is intended for member administration under the direct observation of a

qualified healthcare provider, and members are required to be monitored by a healthcare provider for at least two (2) hours.

- SPRAVATO® must never be dispensed directly to a member for home use.

Background

Esketamine is sold under the brand name SPRAVATO® and is indicated for adults with treatment-resistant depression. Based on the prescribing information, members who have the drug administered in the professional provider's office and outpatient setting should be monitored for two hours to assess for complications.

A main component in understanding how to report the administration of this drug is to identify whether the professional provider has purchased the drug for administration or whether the drug has been supplied and reported by a pharmacy. There are specific codes to report for each scenario:

- Professional Provider Purchased and Administered (Office & Outpatient Hospital Setting)
- Pharmacy Supplied and Professional Provider Administered
- Post – Administration Observation

Eligible

Professional Provider (Office & Outpatient Hospital Setting) Purchased and Administered

If the provider purchases SPRAVATO ®from a specialty distributor that ships the medication to the provider's office then the provider bills Blue Cross VT for SPRAVATO®, the administration, observation and monitoring services.

Billing for SPRAVATO® 1 unit of S0013 equals 1-mg dose of drug administered. For example, bill (56) units of S0013 for the 56-mg dose kit and (84) units for the 84-mg dose kit. Claims with drug services must contain the National Drug Code (NDC) along with the unit of measure and quantity in addition to the applicable Current Procedural Terminology (CPT) or Health Care Procedure Coding System (HCPCS) codes(s). (Refer to Provider Handbook for further information).

Revenue code 0636 may be used in an outpatient setting.

Provider Billing Guidelines and Documentation

General guidelines for reporting the administration, observation and monitoring of SPRAVATO®

Select the appropriate procedure code based on the time involved in supervising and monitoring of the SPRAVATO® administration in the office or outpatient setting. Medical records must support coding.

The Evaluation and Management (E/M) services to which these guidelines apply require a face-to-face encounter of the member with the provider or other qualified health care professional.

Use the time defined in the procedure code descriptors to select the appropriate level of service.

Code	Descriptor
99202-99205	New Patient Visit Level 2-5
99212-99215	Established Patient Visit Level 2-5
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services.) (Do not report G2212 on the same date of service as codes 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)

Reporting Prolonged Services

If services provided during the SPRAVATO® encounter exceeds the time captured by standard E/M coding, use prolonged service code G2212. Examples provided below.

Note: G2212 can only be billed for each additional 15 minutes.

Example of initial and multiple units of prolonged service(s) – New Patient

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
Less than 75 minutes	Not reported separately
75-89 minutes	99205 X1 (one unit) and G2212 X 1 (one unit)
90-104 minutes	99205 X1 (one unit) and G2212 X 2 (two units)
105 minutes or more	99205 X1 (one unit) and G2212 X 3 (three units or more) or

	more for each additional 15 minutes

For services 55 minutes or longer, use prolonged services code G2212
Example of initial and multiple units of prolonged service(s) – Established Patient

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
Less than 55 minutes	Not reported separately
56-70	99215 X1 (one unit) and G2212 X 1 (one unit)
71-85	99215 X1 (one unit) and G2212 X 2 (two units)
86 minutes or more	99215 X1 (one unit) and G2212 X 3 (three units or more) or more for each additional 15 minutes

Not Eligible

The following services are not eligible for benefits and if billed, will result in the service(s) denying as a provider liability:

- SPRAVATO® billed by anyone other than the provider/pharmacy who purchased the drug
- Facility claims containing the revenue code 0250
- Psychotherapy and monitoring provided concurrently during SPRAVATO® administration as a form of psychedelic-assisted therapy, like Ketamine Assisted Therapy (KAP)
  Note: Waivers (Informed consent) may be obtained for services that are considered not eligible for payment as noted in this payment policy which allows the member to be billed if certain steps are followed. (Refer to the Provider Handbook for more information).
- Prolonged visit codes 99415, 99416 and 99417
  Note: 99415 and 99416 are also supervised billing codes also referred to as "incident to," and is generally not allowed. Providers who render care to our members must be licensed, credentialed and enrolled. Refer to our Provider Handbook for more information.

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.

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

N/A

Related Policies

Ketamine Corporate Medical Policy

Provider Handbook

References

American Medical Association. (2025). CPT®: Current Procedural Terminology (Professional). 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 December 12, 2025.

Date of Change	Effective Date	Overview of Change
December 12, 2024	April 01, 2025	New policy. Created payment policy statement to outline purchase options and billing information for the administration and observation of the drug SPRAVATO®(Esketamine) in a provider office and outpatient setting

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

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