BlueCross BlueShield of Vermont
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TEMPORARY/EMERGENCY POLICY: TELEPHONE TRIAGE
Corporate Payment Policy
Effective March 19, 2020

File Name: CPP_25 BCBSVT Payment Policy (Temporary/Emergency): Telephone Triage
Policy No.: CPP_25
Next Review: 60 days after implementation
Effective Date: March 19, 2020

Document Precedence

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

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

Payment Policy

Description

This policy outlines BCBSVT payment for telephone check-ins (also referred to as "telephone triage" services) on an emergency/temporary basis in light of the COVID-19 pandemic. The purpose of this policy is to recognize the influx of calls providers are fielding and to allow patients to connect with their providers without going in to the providers' offices. These brief check-in services are for patients with an established relationship with a provider and where communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available).

Policy

BCBSVT will pay for telephone triage services on an emergency/temporary basis in the context of the COVID-19 pandemic. These services are not intended to be a substitute for an in-person visit or an office

visit conducted via telemedicine (for office visits conducted by telephone-only or telemedicine means, please see BCBSVT's Corporate Payment Policy on Telemedicine and BCBSVT's Temporary/Emergency Corporate Payment Policy on Telephone-Only Services). The payment for telephone triage services is intended to ensure providers can appropriately staff phone lines to respond to member inquiries and avoid unnecessary visits to health care provider offices and hospitals.

BCBSVT will reimburse for G2012 when billed by physicians or other qualified health care professionals (including licensed practical nurses (LPNs) and registered nurses (RNs).

Code	Description
G2012	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, 5-10 minutes of medical discussion

Provider Billing Guidelines and Documentation

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

The code listed in this policy should be billed where an episode of care is initiated by an established patient, parent, or guardian.

Providers should submit the claim on a professional claim form using place of service (POS) 02.

The code listed in this policy should NOT be billed in the following circumstances:

- Calls initiated by a qualified health care professional
- Calls made during a post-operative period of a procedure
- Where the patient is seen at the next available urgent care appointment
- Where the patient is seen within 24 hours of the call
- Calls involving monitoring of INR
- Telephone services that are considered part of a previous or subsequent service
- If the code has been billed for that patient within the past seven days
- The call is an appointment reminder
- The call is for the purpose of communicating normal routine results or other information that may be communicated by non-licensed staff

The visit should be documented in the medical record and include the following elements:

- Notation that patient consented to the consult held via telephone
- Names of all people during the telephone consultation and their roles
- Chief complaint or reason for telephone visit
- Relevant history, background, and/or results
- Assessment

- Plan and next steps
- Total time spent on medical discussion
- Any other documentation necessary to meet BCBSVT standards, policies, and procedures

Benefit Determination Guidance

Payment for telephone triage 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. BCBSVT intends to pay for these services at no cost share irrespective of benefits during this emergency period for fully insured customers. However, some self-funded employers may elect not to do so.

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

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

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

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at http://www.bcbsvt.com/provider-home for the latest news and communications.

Eligible Providers

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

Audit Information:

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

Related Policies

CPP_24 Temporary/Emergency Payment Policy: Telephone-only Services
CPP_03 Payment Policy: Telemedicine
Medical and Treatment Records Standards

Policy Implementation/Update Information

Effective March 19, 2020; to reviewed on or before May 15, 2020

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Approved by **Date Approved:** 3/19/2020

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