



BlueCross BlueShield of Vermont

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**TEMPORARY/EMERGENCY POLICY:
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY SERVICES BY
TELEMEDICINE
Corporate Payment Policy
Effective March 20, 2020**

File Name: BCBSVT Corporate Payment Policy 27 (Temporary/Emergency): Physical Therapy, Occupational Therapy, and Speech Therapy Services by Telemedicine

Policy No.: CPP_27

Last Review: March 2020

Next Review: 60 days after implementation

Effective Date: March 20, 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 payment policy is implemented in the context of the coronavirus pandemic and in an effort to improve social distancing.

BCBSVT’s Corporate Payment Policy on Telemedicine continues to apply for the services identified in that policy and rendered via HIPAA-compliant audio/ video means. This policy supplements that existing policy for certain physical therapy, occupational therapy, and speech therapy services, on a temporary/emergency basis.



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Policy

On a temporary/emergency basis, BCBSVT will pay for certain physical therapy, occupational therapy, and speech therapy services when:

- Services are provided to an existing patient,
- Services are rendered via HIPAA-compliant audio/video telemedicine means, and
- When the visit is between a provider and a patient (or parent of a patient under the age of 12)

The Provider is responsible for:

- Obtaining verbal or written consent from the patient or the patient's adult representative for the use of telemedicine to conduct the visit
- Documenting this consent in the patient's medical record
- Advising the patient that the visit is a physical therapy, occupational therapy, or speech therapy evaluation service and that it will be billed to BCBSVT
- Billing the telemedicine visit with a -95 modifier and place of service (02) (for CPT® codes) or -GT modifier (for HCPCS codes) so that the use of telemedicine services may be identified
- Documenting the visit in accordance with standard requirements, including the requirements set forth in the applicable BCBSVT corporate medical policies for PT/OT/ST services. These requirements include, but are not limited to the following:
 - Documentation that the patient has been informed this is considered therapy service and will be billed to BCBSVT as such
 - If applicable, documentation of the patient history
 - If applicable, documentation of the assessment
 - If applicable (for physical therapy services), documentation of the examination of body systems
 - Documentation of the member's individualized treatment plan;
 - Progress notes demonstrating evidence of improvement and/or lack of improvement or regression
 - When time is a component of the code billed, the documentation must include the total time, or the start and end times of the individual therapies performed
- Using telemedicine only for visits that fall within the standard of care and that can be reasonably and safely handled via telemedicine

Not Eligible for Payment

Any services delivered pursuant to the terms of this temporary policy should be appropriate for delivery through telemedicine. Services not appropriate for delivery via telemedicine may not be reimbursed.

Eligible Services

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



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Benefit Determination Guidance

Payment for PT/OT/ST services delivered via telemedicine 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. Member cost sharing under this policy will be the same cost sharing that would apply had the services been delivered in-person.

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.

Provider Billing Guidelines and Documentation

See the Policy section, above.

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.



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Eligible Providers

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

Audit Information:

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

Related Policies/References:

BCBSVT Corporate Payment Policy 03 – Telemedicine
BCBSVT Corporate Payment Policy 24 (Temporary/Emergency) – Telephone-only Services
BCBSVT Corporate Payment Policy 25 (Temporary/Emergency) – Telephone Triage
BCBSVT Medical and Treatment Record Standards Policy
BCBSVT Corporate Medical Policy: Physical Therapy/Medicine
BCBSVT Corporate Medical Policy: Speech Language Pathology/Therapy Services
BCBSVT Corporate Medical Policy: Occupational Therapy

Reference: American Medical Association. (2020). *CPT®: Current Procedural Terminology (Professional)*. Chicago IL: American Medical Association.

Policy Implementation/Update Information

This policy is implemented on an emergency/temporary basis effective March 20, 2020. The policy will be reviewed on or before May 15, 2020.



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Approved by

Date Approved: _____ 3/20/2020 _____

Josh Plavin MD, MPH

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

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Dawn Schneiderman, Vice President, Chief Operating Officer



Attachment 1: Coding Table

The following will be considered as Medically Necessary when applicable criteria have been met.

Code	Description	Instructions
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits
92524	Behavioral and qualitative analysis of voice and resonance	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits
92526	Treatment of swallowing dysfunction and/or oral function for feeding	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits
97130 +	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits



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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.	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits
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 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.	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits



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<p>97164</p>	<p>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.</p>	<p>Telemedicine Therapy Visits will Count Towards Therapy Visit Limits</p>
<p>97165</p>	<p>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. 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.</p>	<p>Telemedicine Therapy Visits will Count Towards Therapy Visit Limits</p>



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<p>97166</p>	<p>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.</p>	<p>Telemedicine Therapy Visits will Count Towards Therapy Visit Limits</p>
<p>97167</p>	<p>Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.</p>	<p>Telemedicine Therapy Visits will Count Towards Therapy Visit Limits</p>



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97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits
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	Telemedicine Therapy Visits will Count Towards Therapy Visit Limits