Telehealth (Telemedicine) – Behavioral Health

Payment policy

MASSACHUSETTS

Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) reimburses contracted health care providers for covered, medically necessary behavioral health telehealth (telemedicine) services.

In line with Chapter 224 of the Acts of 2012, Blue Cross defines telemedicine as *the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment*. Telehealth (telemedicine) does not include the use of audio-only telephone, fax machine, or email.

Blue Cross providers must deliver telehealth (telemedicine) services via a secure and private data connection. All transactions and data communication must comply with the Health Insurance Portability and Accountability Act (HIPAA). For more information on HIPAA and electronic protected health information (EPHI) compliance, please see: hhs.gov/ocr/privacy/hipaa/understanding/srsummary.html.

Asynchronous telecommunication

Medical information is stored and forwarded to be reviewed later by a physician or health care practitioner at a distant site. The medical information is reviewed without the patient being present. Asynchronous telecommunication is also referred to **as store-and-forward telehealth** or **non-interactive telecommunication**.

Interactive audio and video telecommunication

Medical information is communicated in real-time with the use of interactive audio and video communications equipment. The real-time communication is between the patient and a distant physician or health care specialist who is performing the service reported. The patient must be present and participating throughout the communication.

Telehealth

Telehealth is a broader term which includes telemedicine.

General benefit information

Covered services and payment are based on the member's benefit plan and provider Agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our eTools page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayments, deductibles, and co-insurance. Members' costs depend on member benefits.

Certain services require prior authorization or referral.

Payment information

Blue Cross reimburses health care providers based on your contracted rates and member benefits.

Claims are subject to payment edits, which Blue Cross updates regularly.

Blue Cross reimburses

- Certain *behavioral health codes* when submitted with modifier **GT** or modifier **95** as listed in the billing information section below
  - Psychiatric diagnostic evaluation
  - Psychotherapy
  - Family psychotherapy
- Certain *evaluation and management codes* when submitted with modifier **GT** or modifier **95** as listed in the billing information section below
- **Certain telehealth (i.e.: telephonic) services as indicated below in response to COVID-19.**

Blue Cross does not reimburse

This section does not apply during the COVID-19 response period.

- Any services not defined with modifier GT or modifier 95
- Asynchronous telecommunication
- Costs associated with enabling or maintaining contracted providers' telehealth (telemedicine) technologies
- Interprofessional telephone or internet consultations
- Online medical evaluation
- Telephone services

General reimbursement information

- Modifier GT and modifier 95
    - Behavioral health practitioners must use modifier GT or 95 (via interactive audio and video telecommunications systems) to differentiate a telehealth (telemedicine) encounter from an in-person encounter with the patient.
    - When reporting modifier GT or 95, the practitioner is attesting that services were rendered to a patient via an interactive audio and visual telecommunications system. **This statement does not apply during the COVID-19 response period.**

- Reimbursement
    - Reimbursement for telehealth (telemedicine) services is calculated using a reduced Practice Expense (PE) Relative Value Unit (RVU). See the CPT and HCPCS Modifiers Payment Policy for additional information.
    - Behavioral health specialties are limited to codes on their fee schedules.
    - **Please see below regarding reimbursement during the COVID-19 response period.**

- Telehealth (telemedicine) services are reimbursed when the following criteria are met:
    - The provider is contracted with Blue Cross Blue Shield of Massachusetts or is providing services through a telehealth or telemedicine vendor contracted with another Blue Cross Blue Shield Plan, and meets all terms and conditions of the applicable contracts, including credentialing and licensure.
    - The provider renders care from the location listed in his or her contract with Blue Cross Blue Shield of Massachusetts or other appropriate location(s) within Massachusetts, in a professional, non-public space.

COVID-19

Effective for dates of service retroactive to March 16, 2020, Blue Cross will reimburse **all** covered services (COVID-19 AND non-COVID 19 related) whether they are telehealth or telephonic (audio). Follow the same telehealth billing guidelines including the use of the following modifiers:

- Practitioners must use modifier GT, 95, G0, or GQ (via synchronous/asynchronous telehealth audio and/or video telecommunications systems) to differentiate a telehealth (telemedicine) encounter from an in-person encounter with the patient.
- **Any telehealth or telephonic service must be reported with modifier GT, 95, G0, or GQ and place of service code 02. Blue Cross will allow the use of these modifiers and place of service code on any code during the COVID-19 response period.**

Ancillary and Behavioral Health Providers:

(This section only applies to certain specialties. Click here to find out if your specialty is included.)

- When you provide any telephonic services, do not bill the specific telephonic CPT codes. Bill all covered services that you render either by telehealth/video or telephone as if you are performing a face-to-face service using the codes that are currently on your fee schedule.
- You must use one of the following telehealth modifiers (GT, 95, G0, and GQ) and place of service code 02. This will enable us to pay you the same rate we pay you for in-person, face-to-face visits.
- **Blue Cross will allow the use of these modifiers and place of service code for any service on your fee schedule during the COVID-19 response period.**

Blue Cross expects the documentation and medical records to support the criteria of the service billed.

Please refer to the coding grid below for applicable codes. Note, this list is not all inclusive. Whether or not a code is listed here does not guarantee coverage or reimbursement.

Billing information

Specific billing guidelines
The list of codes below is included for *informational purposes only*. This may not be a complete list of all the codes related to this service. Whether or not a code is listed here does not guarantee coverage or reimbursement.

- The following codes are reimbursable when submitted with either modifier GT, 95, or G0.
- Services rendered must fall within the scope of the provider's license.

Code	Service description	Comments
Modifiers		
GT	Via interactive audio and video telecommunication systems	**Blue Cross will allow the use of these modifiers on any code during the COVID-19 response period.**
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system	
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke	
GQ	Via asynchronous telecommunications system	
CPT and HCPCS codes		
90791	Psychiatric diagnostic evaluation	
90792	Psychiatric diagnostic evaluation with medical services	Effective 7/1/19
90832	Psychotherapy, 30 minutes with patient and/or family member	
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service	
90834	Psychotherapy, 45 minutes with patient and/or family member	
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service	
90837	Psychotherapy, 60 minutes with patient and/or family member, consistent with the face-to-face visit	
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)	
90846	Family psychotherapy (without the patient present), 50 minutes	Effective 7/1/19
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	
98966	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian; 5-10 minutes of medical discussion	Effective 3/16/2020, temporarily accepted until further notice
98967	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian; 11-20 minutes of medical discussion	Effective 3/16/2020, temporarily accepted until further notice
98968	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian; 21-30 minutes of medical discussion	Effective 3/16/2020, temporarily accepted until further notice
98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
99201	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 10 minutes are spent face to face with the patient and/or family.	

Code	Service description	Comments
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	Effective 7/1/19
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family	Effective 7/1/19
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family	Effective 7/1/19
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family	Effective 7/1/19
99211	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 5 minutes are spent performing or supervising these services.	
99212	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 10 minutes are spent face to face with patient and/or family	
99213	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 15 minutes are spent face-to-face with the patient and/or family	
99214	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 25 minutes are spent face-to-face with the patient and/or family	
99215	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 40 minutes are spent face-to-face with the patient and/or family	Effective 3/16/2020, temporarily accepted until further notice
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Effective 3/16/2020, temporarily accepted for FEP and Medicare

Code	Service description	Comments
		Advantage products until further notice
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian; 5-10 minutes of medical discussion	Effective 3/16/2020, temporarily accepted until further notice
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian; 11-20 minutes of medical discussion	Effective 3/16/2020, temporarily accepted until further notice
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian; 21-30 minutes of medical discussion	Effective 3/16/2020, temporarily accepted until further notice
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 Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge	Effective 3/16/2020, temporarily accepted until further notice
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 Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge	Effective 3/16/2020, temporarily accepted until further notice
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	Effective 3/16/2020, temporarily accepted until further notice
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	Effective 3/16/2020, temporarily accepted for Medicare

Code	Service description	Comments
		Advantage products until further notice
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	Effective 3/16/2020, temporarily accepted for Medicare Advantage products until further notice
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	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
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	Effective 3/16/2020, temporarily accepted until further notice
G2061	Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
G2062	Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice
G2063	Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Effective 3/16/2020, temporarily accepted for FEP and Medicare Advantage products until further notice

When submitting claims, report all services with:

- Up-to-date, industry-standard procedure and diagnosis codes, and
- Modifiers that affect payment in the first modifier field, followed by informational modifiers

Related policies

Note: Log into Provider Central before clicking Payment Policy links.

Behavioral Health and Substance Use
CPT and HCPCS Modifiers
Evaluation and Management
General Coding and Billing
Non-Reimbursable Services
Telehealth (Telemedicine) – Medical

Policy update history

02/01/2018	Documentation of policy
06/01/2018	Policy renamed to Telehealth (Telemedicine) – Behavioral Health
10/19/2018	Edits for clarity in the coding grid
12/31/2018	Annual coding review; inclusion of G2010
03/31/2019	Annual review; addition of modifiers GT and 95 to the coding grid; addition of related policies
06/01/2019	Addition of the following codes effective 7/1/19: 99202, 99203, 99204, 99205, 90792, 90846
06/30/2019	Edits for clarity on reimbursement criteria for telemedicine services
12/31/2019	Annual coding review; deleted 98969 and 99444, added 98970-98972, 99421-99423, G2061-G2063

03/13/2020	Addition of 99215 effective 3/16/20
03/18/2020	Addition of temporary coding information in response to COVID-19
03/23/2020	Revision of COVID-19 billing information; removal of the following codes 98970-72, 99421-23, G2061-63, G0406-08, G0425-27, G0508-09; inclusion of modifier GQ
03/24/2020	Addition of the following codes applicable to FEP and Medicare Advantage products: 98970-72, 99421-23, G2061-63, G0406-08, G0425-27, G0508-09

This document is for informational purposes only and is not an authorization, an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts' payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy development takes into consideration a variety of factors, including: the terms of the participating provider's contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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