Telehealth Coding Quick Reference Guide

	E&M Codes		Virtual Communications		Advanced Care Planning		Medicare-Specific Wellness Codes	
Codes *Consistent across all payers*	**99201-99205**	**99211-99215**	**G2012 & G2010**	**99421-99423**	**99497**	**99498**	**G0438**	**G0439**
Description	**New Patient E/M**	**Est. Patient E/M**	**Virtual Check-in Telephone Encounter**	**E-visit**	**Advanced Care Planning**	**Advanced Care Planning *(addl 30 min)***	**Initial Annual Wellness Visit**	**Subsequent Annual Wellness Visit**
Modifier *Consistent across all payers*	Modifier 95		No modifier needed as these are technology-based codes		Modifier 95			
POS *Varies by payer*	POS 11 (BCBS & Aetna use POS 02)							
Can I bill an E&M also?	N/A		No		Yes -- Add medically necessary E&M code, add modifier 33 with AWV (Coinsurance will not apply when on same day with AWV)		Yes -- Add medically necessary E&M code with Modifier 25	
Same reimbursement as in-office?	Yes		N/A		Yes			
Audio only ok?	Yes							
Other considerations	These are the most common CPT codes to use for Telehealth in Primary Care		These codes are not intended to replace in-office E/M visit codes and are seldomly reimbursed by commercial payers when used **with** E/M codes		Forms are not required to be completed during this visit type and there are no frequency limitations		Frequency is a crucial component when using these codes. Schedulers should always verify timing of last AWV prior to scheduling a future AWV.	
Commercial Payers?	Yes		Medicare approved but can vary with commercial payers					
Examples	Sick visits, Chronic condition monitoring, general evaluation, medication management, etc.		G2012 Phone call with a QHP to decide if an appointment or other service is needed G2010 evaluation or interpretation of video or images submitted by the patient	A patient emails for a brief check-in with a QHP via portal or email to decide whether an office visit or other service is needed	These codes can be used for appointments dedicated solely to advanced care planning or can be used an additional service during a typical E/M or preventative visit		This is an AWV with a Medicare patient during their second year of eligibility (this is different from the Welcome to Medicare visit which uses code G0402 and is not a CMS approved Telehealth code)	This is an AWV with a Medicare patient one year after the patient's initial AWV (G0438) and is only allowed one time every 12 months

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<tr><th colspan="4">Additional Tips</th></tr>
<tr><td>Monitoring Reimbursements</td><td colspan="3">Compare the reimbursement rates for telehealth claims at least 1 time per week to catch claims that have been reimbursed incorrectly & appeal denials as needed</td></tr>
<tr><td>Timely Filing</td><td colspan="3">Claims should be filed as soon as possible to allow for prompt payment and avoid denials. Timely filing limits vary by payer but on average range from 60-180 days.</td></tr>
<tr><td>Collecting Copays</td><td colspan="3">As of 3/31/2020 Aetna, BCBS, and UHC have waived copays for telehealth visits. Copays should be collected as normal except for COVID-19 related visits for Cigna and Medicare.</td></tr>
<tr><td>Waiving Cost Share</td><td colspan="3">Cigna and Medicare require the use of the CS modifier to waive cost sharing for COVID-19 related visits</td></tr>
<tr><td>Denial Codes & Corrective Actions</td><td colspan="3">Telehealth claims: 99213 billed with POS 11 and Modifier 95</td></tr>
<tr><td></td><td>Example 1: BCBS of Texas – PPO
Denial Reason: Benefit Level
Adjustment Reason Code PR-96: Non- Coverage Charge (Patient Responsibility)
Remark Code N130: Consult plan Benefit Documents/Guidelines for information about restrictions for this service
Corrective Action: Self-funded payer benefit included MDLive platform (Murphy USA). Patient is responsible for visit and was encouraged to reach out to employer. Catalyst Health Network also contacted BCBS Texas Provider Representative.</td><td>BCBS of Texas – PPO
Denial Reason: Medical Necessity
Adjustment reason code PR-50: These are non-covered services because this is not deemed a ‘medical necessity’ by the payer
Remark Code N661: Documentation does not support medical necessity
Corrective action: Payer was contacted and verbal appeal for medical necessity based on diagnosis of Exposure to COVID-19 along with screening ordered due to signs and symptoms of COVID-19. Payer is reprocessing claim.</td><td>UMR
Denial Reason: Diagnosis
Adjustment reason code PI-11: diagnosis is inconsistent with procedure PI-11
Remark Code N657: This should be billed with the appropriate code for these services.
Corrective Action: Appeal pending with payer with progress note and corrected claim documentation to support updated symptoms of cough, fever, and progress notes that indicate family tested positive for flu. Additional diagnosis documentation may have avoided denial.</td></tr>
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