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Q & A: Coding for Telemedicine Services in 2025

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Article Highlights

This article addresses questions that may arise with implementation of code changes for telemedicine services provided on and after January 1, 2025. The topics addressed by these questions and answers include the following:

- General questions about reporting telemedicine services
- Services affected by 2025 telemedicine code changes
- Applicability of telemedicine modifiers
- Locations of service

Information in this article is accurate based on *Current Procedural Terminology* (*CPT*®) guidance and Medicare policies (often adopted by other payers) available at the time of writing. All information is subject to change as telemedicine regulations, codes, reporting guidelines, and payment policies continue to evolve.

Code descriptors and code-specific information for audio-video evaluation and management (E/M) services (**98000–98007**), audio-only E/M services (**98008–98015**), and brief communication technology-based E/M service (**98016**) are provided in additional articles in this series, including "*CPT 2025*: An Overview of Telemedicine Code Changes" (available in the November 2024 issue,

General Questions About Reporting Telemedicine Services

1. Which types of health care professionals can report the new telemedicine codes?

Only physicians and other qualified health care professionals (QHPs) whose scope of practice includes E/M services can provide and report the new telemedicine E/M

codes (**98000–98016**). These services are not reported by nonphysician qualified health care professionals (NQHCPs) whose scope of practice includes assessment and management services but not E/M services (eg, occupational therapists, physical therapists). Do not report **98000–98016** for services provided by clinical staff with or without supervision of a physician or other QHP.

NQHCPs should continue to report codes **98966–98968** for assessment and management telephone services. For audio-video telemedicine services, those codes that are preceded by a star (★) symbol in *CPT* and reported with modifier **95** (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) should be reported (eg, **97161–97164**, physical therapy evaluations).

2. Can the brief communication technology-based visit code 98016 be reported for a visit using audio-video technology when the total time of service is less than 10 minutes?

While it may be possible to report **98016** for an audio-video telemedicine service with total time of 5 to 10 minutes, other criteria must be met to report **98016**.

- The service must be initiated by a patient or parent/caregiver.
- The patient must be an established patient to the physician or QHP.
- The purpose of the service is to determine if more extensive service is required.

However, codes for audio-video telemedicine services may be reported based on medical decision-making (MDM) regardless of the physician's or QHP's total time on the date of service. Consider that level 1 codes for audio-video telemedicine services (ie, new patient, **98000**; established patient, **98004**) require only straightforward MDM. Straightforward MDM is supported when 1 self-limited or minor problem is addressed in conjunction with minimal or no data or minimal risk of morbidity from additional diagnostic testing or treatment. Codes **98000–98007** may be reported when an audio-video telemedicine E/M is the only E/M service rendered to the patient by the reporting physician or QHP (including other physicians or QHPs of the same specialty and subspecialty in the same group practice) on the date of service.

3. When selecting a code for audio-only telemedicine services (98008–98015), is the required time of interactive communication included in the total time on the date of service?

Yes, but time of greater than 10 minutes spent in medical discussion (ie, interactive synchronous communication) must be documented separately from the physician's or QHP's total time on the date of service (eg, total time, 25 minutes, *with more than 10 minutes in medical discussion*). Do not report **98008–98015** when the time spent in medical discussion is not greater than 10 minutes, even if the MDM or total time is otherwise sufficient to support code selection.

4. Does the total time of telemedicine services reported with 98000–98015 include time spent to establish a connection through the telecommunications technology?

No. The time spent establishing a connection, whether performed by clinical staff or by the physician or QHP providing the service, is part of the practice expense of the service and not the total time of service, which represents physician work.

5. How is a service that began with audio-video communication reported when the visit is converted to audio-only due to technical difficulties?

When audio-video connections are lost during an encounter and only audio is restored, report the service that accounted for the majority of the time of the interactive portion of the service (not the total time of service). Documentation should include the time spent via each type of communication technology to support the code selection. Do not report the service when the time of medical discussion is less than 10 minutes.

Services Affected by 2025 Telemedicine Code Changes

1. Do the 2025 code changes affect how we report hospital consultations and hospital care?

No. The new codes implemented for services on and after January 1, 2025, do not affect how services to patients in a hospital inpatient or observation stay are

reported. For services described by codes that are preceded by a star (★) symbol, modifier **95** may be appended to indicate the service was provided via telehealth (eg, inpatient or observation consultations, **99252–99255 95**). Continue to follow payer guidance for reporting other services to hospitalized patients (eg, initial hospital care or remote critical care services). A payer may use Healthcare Common Procedure Coding System codes and/or modifiers (eg, **GT**, via interactive audio and video telecommunication systems) to allow payment for those services that are not reported with modifier **95**.

TIP

Some payers will consider modifier **95** informational only. When modifier **95** is considered for information only, the correct place of service (POS) code (**02** or **10**) is used to determine the allowed amount for services provided via telemedicine.

2. How do the audio-only telemedicine E/M codes (98008–98015) compare with telephone E/M codes (99441–99443)?

There are significant differences in the services described by the telephone E/M service codes (**99441–99443**), which are deleted from *CPT 2025*, and the new audio-only E/M codes (**98008–98015**). Compare these codes using the **Table**.

Applicability of Telemedicine Modifiers

1. Will modifiers 93 and 95 be reported in 2025?

Yes. However, modifier **95** will no longer be appended to codes **99202–99205** or **99212–99215** because, when provided via telemedicine, the services will be reported with new audio-video E/M codes.

Telemedicine modifiers **93** and **95** will continue to be used with codes preceded by the applicable symbols (🕪 or ★) and included in Appendixes P and T of *CPT 2025*.

Comparison of 2024 Telephone Service Codes to 2025 Audio-Only Telemedicine Codes

Telephone E/M Services (99441–99443)	Audio-Only Telemedicine Services (98008–98015)
Considered non–face-to-face services rather than telemedicine services	Are telemedicine services as defined in *CPT 2025*

Telephone E/M Services (99441–99443)	Audio-Only Telemedicine Services (98008–98015)
Applicable only to established patient visits	Applicable to new or established patient visits
The service must be initiated by the patient or parent/caregiver.	May be initiated by the patient, parent or caregiver, or the physician or other QHP.
Are not reported if the same physician or QHP reported an E/M service provided to the patient within the last 7 days.	Do not require a specific time interval from the last in-person or telemedicine visit.
Are not reported if the telephone service ends with a decision for an in-person visit within 24 hours or at the next available appointment.	Must be performed on a separate calendar date from another E/M service.
Require a minimum of 5 minutes of medical discussion.	Must exceed 10 minutes of medical discussion and meet required MDM or total time.
Are selected only based on time of medical discussion.	Are selected based on either total time or MDM, but the time spent in medical discussion must exceed 10 minutes.

Abbreviations: *CPT, Current Procedural Terminology;* E/M, evaluation and management; MDM, medical decision-making; QHP, qualified health care professional.

Examples of services that will be reported with modifiers include the following (not all-inclusive):

- **93:** Applicable to services provided via synchronous audio-only communication technology
    - Tobacco and smoking cessation counseling visits (**99406–99407**)
    - Brief intervention for alcohol and substance use (**99408–99409**)
    - Advance care planning (**99497–99498**)
    - Psychiatric diagnostic evaluation (**90791** or **90792**)
    - Psychotherapy services (**90785**, **90832–90847**)
    - Developmental screening (**96110**)
    - Administration of health risk assessment (**96160** or **96161**)
- **95**: Applicable to services provided via synchronous audio-video communication technology
    - Office or other outpatient visit not requiring the presence of a physician or QHP (**99211**)
    - Subsequent hospital care (**99231–99233**)

- Office and other consultation services (**99242–99245**)
- Transitional care management (**99495** or **99496**)
- Psychiatric diagnostic evaluation (**90791** or **90792**)
- Psychotherapy services (**90785**, **90832–90847**)

See *CPT* Appendixes P and T for the full list of codes to which these modifiers are applicable.

Locations of Service

1. New codes 98000–98016 do not specify a POS (eg, office). Are these codes reported for services provided to patients who are located in their homes, or can the patient be located in a facility setting (eg, hospital, nursing home)?

Patients receiving telemedicine services described by the new codes may be located in their homes or another residential setting but might also receive services in other settings (eg, school). As indicated by the subcategorization of the new codes to describe services to new or established patients, **98000–98015** do not describe services provided to patients during a stay in a health care facility or in the emergency department that are reported with codes specific to those settings.

2. Must the physician or QHP providing an audio-video or audio-only service be located in a particular setting?

CPT does not address the location of the physician or QHP providing the service. However, practice locations may be required by contractual agreements with payers. With an increase in payable services that may be provided by a physician or QHP who is practicing from home, practice managers and administrators should be aware of local and regional payer policies that could require inclusion of the physician's or QHP's home as a site of service. Payers that use Medicare telemedicine policy will accept currently enrolled practice locations in lieu of a home address even though the physician or QHP is practicing from home.

3. What POS code is reported on claims for telemedicine services reported with 98000–98016?

Report POS code **10** (telehealth provided in a patient's home) when the patient receives the telemedicine service in their home or other private residential setting.

When the patient is located in a non-residential setting, POS code **02** (telehealth provided other than in a patient's home) is applicable. Payers that have adopted the Medicare program policy for telemedicine POS codes will consider POS **10** a non-facility setting and POS **02** a facility setting. Services provided in non-facility settings typically are assigned higher practice expense relative value units (RVUs) that support higher total RVUs and higher payment.

Key Takeaways

This article addressed questions related to reporting telemedicine services provided on and after January 1, 2025.

- Only physicians and other QHPs whose scope of practice includes E/M services can provide and report telemedicine E/M codes (**98000–98016**).
- Patients receiving telemedicine services described by **98000–98016** may be located in their homes or another residential setting but might also receive services in other settings (eg, school).
- Codes **98000–98015** do not describe services to a patient during a stay in a health care facility (eg, hospital inpatient or observation or a nursing facility) or an emergency department visit that are reported with codes specific to those settings.
- There are significant differences between the services described by the 2024 telephone E/M service codes (**99441–99443**), which are deleted from *CPT 2025*, and the new audio-only E/M codes (**98008–98015**). It is important to review the code descriptors and reporting instructions for **98008–98015** prior to code selection.
- Codes **98008–98015** are only reported when the documented time spent in medical discussion is greater than 10 minutes, even if the MDM or total time is otherwise sufficient to support code selection.
- When a connection is lost during an audio-video visit and the visit is completed with audio-only communication, select the code based on the service with the greater portion of the interactive time (eg, time of medical discussion or observation).
- Report POS code **10** (telehealth provided in a patient's home) when the patient receives the telemedicine service in their home or other private residential setting and POS code **02** (telehealth provided other than in a patient's home) when the patient is located in a non-residential setting.