

Telemedicine in 2025: Beyond the New Codes

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Article Highlights

This article reviews codes and modifiers beyond those added in 2025 for reporting evaluation and management (E/M) services. It also reviews important considerations for reporting telemedicine services, including the following:

- Codes and modifiers for telemedicine services
- Determining payer policy for telemedicine services
- Documenting telemedicine services

Codes and Modifiers for Telemedicine Services

Much of this issue of *AAP Pediatric Coding Newsletter*[™] is dedicated to discussion of new *Current Procedural Terminology (CPT)*[®] codes for telemedicine services (**98000–98016**).

However, this article’s emphasis is on reporting telemedicine E/M services when new codes for outpatient E/M services delivered by telemedicine are either not appropriate to the service provided or not accepted under a payer’s policy.

Many *CPT* codes are designated as potential telemedicine services by symbols (eg, 📞 , ★) preceding the codes to indicate that modifier **93** (synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system), **95** (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system), or both are applicable. However, audio-only modifier **93** and audio-video modifier **95** are applicable only to E/M services listed in the [Table](#). (See full telemedicine code listings in Appendixes P and T in your *CPT* reference.)

Applicability of *CPT* Telemedicine Modifiers to E/M Codes

Modifier 93 (audio-only telemedicine)
99406–99409 (individual behavior change interventions)
99497–99498 (advance care planning)
Modifier 95 (audio-video telemedicine)
99211 (office or other outpatient visit not requiring the presence of a physician or QHP)
99231–99233 (subsequent hospital services)
99242–99245 (office or other outpatient consultations)
99252–99255 (inpatient or observation consultations)
99307–99310 (established patient nursing facility services)
99406–99409 (individual behavior change interventions)
99417–99418 (prolonged services)
99495–99496 (transitional care management)
99497–99498 (advance care planning)

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

A payer may also accept or require Healthcare Common Procedure Coding System (HCPCS) modifiers, including the following:

FQ	The service was furnished using audio-only communication technology. (Applicable to telehealth for mental health and substance use disorder treatment services furnished to a patient who is home at the time of service.)
GQ	Via asynchronous telecommunications system (applicable to remote interpretation and report of digital images)
GT	Via interactive audio and video telecommunication systems

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When a payer includes coverage of telemedicine services beyond those indicated in *CPT*, specific HCPCS telemedicine codes may be reported.

G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	typically 50 minutes communicating with the patient via telehealth
G0427	typically 70 minutes or more communicating with the patient via telehealth
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth

Determining Payer Policy for Telemedicine Services

To determine how to report telemedicine services in 2025, practices must proactively review health plan payment policies for telemedicine services and create guidance for reporting when payer policy does not align with *CPT* guidance.

Some payers may elect to pay for telemedicine E/M services reported with codes and/or based on instructions that do not align with *CPT*. In particular, rather than paying for services reported with **98000–98016**, some commercial and Medicaid plans may continue to accept office visit codes **99202–99215** without telemedicine modifiers but with place of service code **02** (site other than the patient’s home) or **10** (patient’s home). Except where a payer’s policy differentiates between audio-video and audio-only E/M services, an office E/M code with an appropriate place of service code may be sufficient for paying for telemedicine services as if provided in-person. This is significantly distinct from *CPT* guidance.

To begin accumulating knowledge of payer policies for telemedicine in 2025, a practice may assign an individual or small team to obtain, review, and document the telemedicine policies of the practice’s top 5 payers. Updated policies for some payers may have been available prior to January 1, 2025, but this activity may extend into early 2025. It is important to note that a single payer or network may administer benefits for multiple plans with different payment policies (eg, commercial, Medicaid, or individual plans).

TIP

The titles of payer policies addressing telemedicine services vary. Titles may include terms such as *telehealth*, *telemedicine*, or *digital* or *virtual services*. Practices should be vigilant for applicable policies and any notifications of changes to policies.

Documenting Telemedicine Services

In addition to providing guidance on codes reported for telemedicine services, *CPT* guidelines and payer policies include certain aspects of telemedicine services that should be documented. These include but are not limited to the following:

- Patient and/or family/caregiver informed agreement to receive care via telemedicine (verbal or written, as required by regulation or payer policy)
- The requesting party (eg, patient, another physician or other qualified health care professional [QHP])
- The reason for providing the visit via telemedicine rather than in-person
- Verification of patient and/or parent or caregiver identification (especially for audio-only services)
- Technology used (eg, secure audio-video application, telephone)
- Locations of patient and physician or QHP at the time of service
- Individuals present during the service
- Relevant history, data reviewed, services ordered, and physical examination, when applicable, as well as any other required elements of the service provided (eg, documents completed in advance care planning)
- Assessment and plan of care and/or recommendations
- The physician's or QHP's time, when code selection is based on time (total time and, when applicable, time spent in medical discussion, as detailed in other articles in this issue)

Although this list appears long, nonclinical activities such as patient and/or family/caregiver informed agreement may be performed and documented by staff or as part of the patient's or caregiver's sign-on to an online portal in advance of the service. A practice may also elect to develop documentation templates to help capture key elements of services.

Key Takeaways

This article discussed the following important considerations related to documentation and reporting of telemedicine services, particularly those not reported with E/M codes specific to telemedicine services:

- Audio-only modifier **93** and audio-video modifier **95** are applicable only to a small number of E/M services.
- Practices must proactively review health plan payment policies for telemedicine services and create guidance for reporting when payer policy does not align with *CPT* guidance.
- When a payer includes coverage of telemedicine services beyond those indicated in *CPT*, specific HCPCS telemedicine codes may be reported.
- *CPT* guidelines and payer policies include certain aspects of telemedicine services that should be documented.