Telehealth Services in 2025

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The availability and use of telehealth services is not new in health care. Specifically, the Centers for Medicare & Medicaid Services (CMS) has had guidelines and reimbursement for telehealth services since January 1999.[1] In response to the COVID-19 public health emergency (PHE), CMS established waivers that expanded the use of telehealth services. With the end of the PHE, CMS transitioned many of those waivers back to pre-pandemic guidelines.[2] At the same time, the American Medical Association (AMA) Current Procedure Terminology (CPT®) Editorial Panel created new Category I CPT codes for telemedicine services. The year is now 2025, and providers need to be aware of the options and distinct differences in reporting telehealth and telemedicine services.

To appreciate the state of *telehealth* services in 2025, it is important to review the terminology. CMS uses the term telehealth, whereas the AMA uses the term *telemedicine*. This difference speaks to the organizations' focus and predominant audiences; in the grand scope, however, these terms cover the same topics. A review of definitions clarifies the distinctions between terms:[3-5]

- **Telemedicine**. Using telecommunication technologies to support delivery of medical, diagnostic, and treatment-related services
- **Telehealth**. Similar to telemedicine but includes a wider variety of *remote healthcare services beyond the doctor-patient relationship*
- **Synchronous**. Happens in real-time, with providers and patients communicating directly by audio or video
- **Asynchronous**. *Store and forward*, with providers and patients sharing information directly with each other before or after telehealth appointments.

It is also important to understand the timeline for telehealth service guidelines as outlined by CMS:

- **Pre-pandemic**. Telehealth services provided prior to January 31, 2020
- **COVID-19 Pandemic PHE**. Telehealth services provided from January 31, 2020 to May 11, 2023, with extension of telehealth services through December 31, 2024. (Note: Congress recently extended some waivers and provisions through March 31, 2025.)
- **Post-pandemic**. Telehealth services provided from January 1, 2025, until March 31, 2025, per the Congress extension noted above.

As mentioned above, in response to the changes experienced during the COVID-19 PHE and the expanded use of telehealth services, the AMA created 17 new evaluation and management (E/M) telemedicine codes effective January 1, 2025 (**Table 1**). The new Category I codes include 8 audio-video E/M, 8 audio-only E/M, and 1 brief check-in code.

The 16 new audio-video and audio-only codes share definitions for new and established patient visits similar to those assigned to office/outpatient E/M visits (**CPT 99202-99205** and **99211-99215**). They must be performed using synchronous technology that complies with the Health Insurance Portability and Accountability Act. Providers will use methodology involving either medical decision-making or total time on the date of the encounter, similar to the office/outpatient E/M services. Audio-only visits have a distinct additional requirement: the provider must spend more than 10 minutes in medical discussion with the patient during the encounter. Regardless of whether the provider selects medical decision-making or time, there is a time component to either methodology that should be documented in the note.

As a result of the 8 new audio-only CPT codes created by the AMA, the previous audio-only CPT codes **99441, 99442**, and **99443** were deleted effective January 1, 2025.

The brief check-in code (**CPT 98016**) mirrors the previous CPT code **G2012** that was deleted by CMS effective January 1, 2025. This code is a time-based visit, but there are restrictions for billing. Specifically, if the patient calls the provider, and the call is related to an E/M visit during the last 7 days or results in an E/M visit or procedure during the next 24 hours or soonest available appointment, it is not billable. Further, the brief check-in can only be billed to established patients, and the encounter must be patient-initiated. This code is used when patients establish contact inquiring if they need to be seen or if their issue may be managed over the phone without the need for a visit. If the check-in does not result in a visit, it is a billable service.

Telehealth Services for Medicare Beneficiaries

Note, CMS is not required to implement or use CPT codes created by the AMA. This fact is evident by the number of Healthcare Common Procedure Coding System (HCPCS) codes that start with the letter *G*. HCPCS codes that begin with the letter *G* were created by CMS to replace or apply to a service that the agency believes is not represented by the AMA codes. Within the calendar year (CY) 2025 Medicare Physician Fee Schedule (MPFS) final rule, CMS indicated that it does not believe that there is a need to recognize the audio-video and audio-only telemedicine E/M codes created by the AMA.

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Table 1. AMA (E/M) Telemedicine Codes

CPT Code	Definition
Audio-video E/M	
98000	**Synchronous audio-video** visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **straightforward medical decision-making** (When using total time on the date of the encounter for code selection, **15 minutes must be met or exceeded**.)
98001	..... and **low medical decision-making** (When using total time on the date of the encounter for code selection, **30 minutes must be met or exceeded**.)
98002	..... and **moderate medical decision-making** (When using total time on the date of the encounter for code selection, **45 minutes must be met or exceeded**.)
98003	..... and **high medical decision-making** (When using total time on the date of the encounter for code selection, **60 minutes must be met or exceeded**. For services 75 minutes or longer, use prolonged services code 99417.)
98004	**Synchronous audio-video** visit for the evaluation and management of an **established patient**, which requires a medically appropriate history and/or examination and **straightforward medical decision-making** (When using total time on the date of the encounter for code selection, **10 minutes must be met or exceeded**.)
98005	..... and **low medical decision-making** (When using total time on the date of the encounter for code selection, **20 minutes must be met or exceeded**.)
98006	..... and **moderate medical decision-making** (When using total time on the date of the encounter for code selection, **30 minutes must be met or exceeded**.)
98007	..... and **high medical decision-making** (When using total time on the date of the encounter for code selection, **40 minutes must be met or exceeded**.)
Audio-only E/M	
98008	**Synchronous audio-only** visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, **straightforward medical decision-making**, and *more than 10 minutes of medical discussion* (When using total time on the date of the encounter for code selection, **15 minutes must be met or exceeded**.)
98009	..... **low medical decision-making**, and *more than 10 minutes of medical discussion* (When using total time on the date of the encounter for code selection, **30 minutes must be met or exceeded**.)
98010	..... **moderate medical decision-making**, and *more than 10 minutes of medical discussion* (When using total time on the date of the encounter for code selection, **45 minutes must be met or exceeded**.)
98011	..... **high medical decision-making**, and *more than 10 minutes of medical discussion* (When using total time on the date of the encounter for code selection, **60 minutes must be met or exceeded**. For services 75 minutes or longer, use prolonged services code 99417.)
98012	**Synchronous audio-only visit** for the evaluation and management of **an established patient**, which requires a medically appropriate history and/or examination, **straightforward medical decision-making**, and *more than 10 minutes of medical discussion* (When using total time on the date of the encounter for code selection, **10 minutes must be exceeded**.)
98013	..... **low medical decision-making**, and *more than 10 minutes of medical discussion* (When using total time on the date of the encounter for code selection, **20 minutes must be met or exceeded**.)
98014	..... **moderate medical decision-making**, and *more than 10 minutes of medical discussion* (When using total time on the date of the encounter for code selection, **30 minutes must be met or exceeded**.)
98015	..... **high medical decision-making**, and *more than 10 minutes of medical discussion* (When using total time on the date of the encounter for code selection, **40 minutes must be met or exceeded**. For services 55 minutes or longer, use prolonged services code 99417.)
Brief Check-in E/M	
98016	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services provided to an established patient and not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, with *5-10 minutes of medical discussion*

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Instead, CMS assigned a status indicator, the letter I, to these new codes, meaning that there is a more specific code that should be used for reporting telehealth services to Medicare. CMS indicated that providers should use existing office/outpatient E/M codes (**CPT 99202-99215**) currently on the Medicare telehealth services list. In addition, when reporting the office/outpatient E/M codes, providers should use both the appropriate place of service (POS) code to identify the location of the beneficiary and the appropriate modifier to identify that the service was furnished via audio-only communication technology. Telehealth modifiers and POS codes to use when reporting services to Medicare beneficiaries are:

- **Modifier FQ**. Service was furnished using audio-only communication technology.
- **Modifier 93**. Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.
- **Modifier 95**. Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.
- **POS 02**. Telehealth provided in an area other than a patient's home. Health services and health-related services provided or received through telecommunication technology in a location other than the patient's home.
- **POS 10**. Telehealth provided in a patient's home. Health services or health-related services provided or received through telecommunication technology in the patient's home (a location other than a hospital or other facility where the patient receives care in a private residence).

CMS continues to instruct providers to report telehealth services as they did in CY 2024. However, at the time of the CY 2025 final rule publication, the allowance for the patient to be in their home or in any originating site setting, such as an office or hospital in an urban location, was set to end on January 1, 2025. The expectation was for the extensions and waivers to revert to pre-pandemic guidelines and once again institute the geographic and site-of-service restrictions that require the patient to be at an originating site in a rural office or rural hospital location. The only exception would be for behavioral health/mental health services and end-stage renal disease monthly assessments. These 2 exceptions allow patients to be in their home for these specific telehealth services.

In the early morning of December 21, 2024, President Biden signed into law the American Relief Act, 2025 (H.R. 10545). This legislation extended CMS coverage and reimbursement for telehealth services within the expanded originating site allowances for 3 months (ie, through March 31, 2025). This extension means that oncology patients can continue to be in their homes or at other originating sites that are not solely rural medical site locations. It is important to note that in the event that Congress does not extend telehealth services when they finalize the fiscal year 2025 budget effective April 1, 2025, or does not address this issue through separate legislation, the geographic and site of service restrictions would be instituted.

Additionally, CMS finalized limited exceptions for use of audio-only services. Audio-only visits can be used for behavioral health/mental health services and end-stage renal disease monthly assessments and for beneficiaries who are not capable of, or do not consent to, the use of video technology. Providers can conduct audio-only visits with oncology patients who cannot or will not consent to audio-video telehealth by reporting the appropriate modifier and POS code.

It should be noted that some commercial payers (ie, United Health Care) have aligned with CMS and have chosen not to recognize the new telemedicine codes from the AMA for CY 2025. Providers should review payer policies to determine the exact codes to report for telehealth services.

Documentation of Telehealth Services

Regardless of whether the E/M visit is in person or through interactive telecommunication (ie, audio-video, audio-only) technology, there are basic documentation principles that apply to ensure that the type of visit is clearly documented and that appropriate codes can be billed. Providers should ensure that E/M documentation:

- Identifies if the visit was provided in-person or by telehealth
- Identifies if a telehealth visit is audio-video or audio-only
- Identifies the location of the patient and location of the physician
- Documents the components of the visit
- Documents time, as necessary, to support the use of time-based methodology.

Coding Examples

The following are a few examples of how to report telehealth E/M services to oncology patients.

Medicare Patient: Example 1

An oncologist is in an office setting (**POS 11**); the patient is at their home. This is a visit with a new patient. A total of 37 minutes is spent face to face and not face to face on the date of the encounter, and the visit is conducted using audio-video technology.

Because the physician provides services out of the office setting and the patient is at home, the physician would report **CPT 99203-95**, **POS 10**, and would be paid the non-facility rate for **CPT 99203**. The physician would *not* report **POS 11**. The physician providing services from an office-based setting would report the modifier of the location of the patient. Patients in their home are considered *non-facility* for purposes of telehealth services reimbursement, and a patient at a medical facility is considered to be *facility based* with regard to reimbursement of the E/M visit.

Medicare Patient: Example 2

An oncologist is in an office setting (**POS 11**); the patient is at their home. The patient is an established patient who does not have a phone with video capabilities nor a computer with video capabilities. Patient only has options for an audio-only visit. A total of 23 minutes is spent in direct communication and not face to face on the date of the encounter, and the visit is conducted using audio-only technology.

Because the physician provides services out of the office setting and the patient is at home, the physician would report **CPT 99213-93** (or modifier FQ; CMS considers them equal), **POS 10**, and would be paid the non-facility rate for **CPT 99213**. The physician would *not* report **POS 11**. The physician providing services from an office-based setting would report the modifier of the location of the patient. Patients in their home are considered *non-facility* for purposes of telehealth services reimbursement, and a patient at a *medical facility* is considered to be facility based with regard to reimbursement of the E/M visit.

Medicare Patient: Example 3

The oncologist is in an outpatient hospital setting (**POS 22**); the patient is at their home. The patient is a new patient. A total of 37 minutes is spent face to face and not face to face on the date of the encounter, and the visit is conducted using audio-video technology.

Even though the patient is at home, because the physician provides services out of the outpatient hospital setting, the physician would report **CPT 99203-95**, **POS 22**, and would be paid the facility rate for **CPT 99203**. The physician working in the facility setting would report the POS per the type of facility setting and would be paid at the facility rate for the E/M charge.

Non-Medicare: Example 4

The oncologist is in an office setting (**POS 11**), and the patient is at their home. The patient is a new patient. A total of 37 minutes is spent face to face and not face to face on the date of the encounter, and the visit is conducted using audio-video technology.

Because the physician provides services in a setting out of the office and the patient is at home, the physician would report **CPT 98001**. The POS code depends upon the payer and whether they would direct the physician to report the **POS 10** for the patient at home or direct the physician to report **POS 11** for where in-person services would have been given. Review of payer policy is necessary.

Non-Medicare: Example 5

The oncologist is in an outpatient hospital setting (**POS 22**). The patient is at their home. The patient is an established patient but does not have a phone with video capabilities nor a computer with video capabilities. They only have options for an audio-only visit. A total of 23 minutes is spent in direct communication and not face to face on the date of the encounter; 11 minutes of that time is direct medical discussion, and the visit is conducted using audio-only technology.

Because the physician provides services from an outpatient hospital setting (**POS 22**), and the patient is at home, the physician would report **CPT 98008**. The POS code used depends upon the payer and whether they would direct the physician to report the POS 10 for the patient at home or direct the physician to report **POS 22** for where in-person services would have been given. Review of payer policy is necessary.

Closing Thoughts

It is crucial that providers stay informed about changes in telehealth coding policies. CMS believes many of the services previously expanded for telehealth use during the PHE could easily switch back to in-person visits. If providers believe differently, they need to advocate for themselves and their patients to ensure access to services and continuity of care. OI

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