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Coding Symbols

▲ Revised code
● New code
+ Add-on code
↗ Product pending US Food and Drug Administration approval
Out-of-numerical-sequence code
★ Telemedicine
◂ Synchronous interactive audio
◘ Identifies codes linked to social determinants of health

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2025 Telemedicine Changes: Outpatient Evaluation and Management

This issue of the *AAP Pediatric Coding Newsletter*™ is devoted to discussing the changes to reporting telemedicine services with new codes that will be implemented on January 1, 2025. Codes **98000–98016** were introduced in the article, "*CPT 2025:* An Overview of Telemedicine Code Changes," in the November 2024 newsletter. In this issue, each subcategory of the new telemedicine codes is discussed in detail. All information included in this issue is based strictly on the approved codes and instructions for *Current Procedural Terminology* (*CPT®*) in 2025. Practices should prepare to verify individual health plan policies for reporting telemedicine services provided in 2025 and note any payment policies that do not align with *CPT* instructions.

CPT 2025: Reporting a Brief Communication Technology-Based Service

Article Highlights

This article includes an expanded discussion of new code **98016** (brief communication technology-based evaluation and management [E/M] service) that was introduced in the first article in this series, "*CPT 2025:* An Overview of Telemedicine Code Changes." Topics covered in this article are as follows:

- Code **98016** and similar codes
- Assigned relative value units (RVUs)
- Essentials of the brief communication technology-based E/M service
- Examples: coding **98016** services

Code **98016** *and Similar Codes*

The code descriptor for **98016** might seem familiar to those who have reported services described as level 1 telephone E/M services (ie, **99441**) or reported Healthcare Common Procedure Coding System (HCPCS) code **G2012**. Telephone E/M codes **99441–99443** will be deleted and not reported for services on and after January 1, 2025. The Centers for Medicare & Medicaid Services will deactivate **G2012** for all services on and after January 1, 2025, and instead accept **98016**.

#●98016 Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report E/M 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

99441 Telephone E/M service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian 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 (Not valid for services provided on and after 01/01/2025.)

G2012 Same as **98016**

Telephone assessment and management codes **98966–98968** and HCPCS code **G2251** (virtual check-in service by a nonphysician qualified health care professional [NQHCP]) remain active for reporting services provided by NQHCPs whose scope of practice does not include E/M services (eg, speech-language pathologist, occupational therapist).

Assigned Relative Value Units

Code **98016** is assigned 0.30 work RVUs. The total RVUs are 0.49 for services provided in a non-facility setting and 0.45 for services provided in a facility setting. These RVUs are unadjusted for geographic locality. When multiplied times a conversion factor of $40, **98016** is valued at approximately $19.60 for services provided in a non-facility setting and $18 for services provided in a facility setting. Actual payment may vary based on contractual agreements between the practice and the payer.

Essentials of the Brief Communications Technology-Based E/M Service

The following requirements are noted when breaking down the descriptor for **98016**:

- Only physicians and other qualified health care professionals who can report E/M services (ie, whose scope of practice includes E/M services) may provide and report the service.
- Only established patients (as defined in E/M guidelines) are eligible to receive the service.

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- Reporting limitations related to prior or future services
  - Not reported when originating from a related E/M service within the previous 7 days
  - Not reported when the service leads to an E/M or a procedure within the next 24 hours or at the soonest available appointment
- At least 5 minutes of medical discussion is required.
  - Do not include time spent in other activities (eg, time to establish communication or pre- or postservice time) in the time of medical discussion.

TIP

Services meeting all these requirements with more than 10 minutes of medical discussion may be reported with telemedicine audio-video or audio-only E/M codes when all criteria for those services are met.

Instructions in *Current Procedural Terminology® 2025* indicate other aspects of the brief communication technology-based service, including who initiates the service, the intent of the service, technology requirements, and reporting of other E/M services.

- The service is *patient initiated* (including initiation by a parent or caregiver).
- The intent of the service is to evaluate whether a more extensive visit type is required (eg, an office or other outpatient E/M service [**99212–99215**]).
- Video communication technology is not required but also not prohibited.

When the **98016** service leads to another E/M service *on the same date,* the time spent providing the **98016** service may be combined with the time of the other E/M service (when the code is selected based on total time).

EXAMPLES: CODING **98016** SERVICES

The following examples are intended only to demonstrate appropriate use of **98016** to report brief communication technology-based services and circumstances in which the code is not appropriately reported. These examples are not intended to offer advice on the practice of medicine. Additionally, code assignment must be based on the individual service provided and documented.

1. A parent requests a telephone visit with a physician to determine if a more extensive E/M service is required for a child (established patient) who woke up with a fever and runny nose. The physician documents 8 minutes spent obtaining history related to the patient's illness, providing instructions for home care, and advising of symptoms that may indicate need for further evaluation. The patient has not received a related E/M service in the previous 7 days and does not receive another E/M service on the date of the brief communication technology-based service. Code **98016** is reported.
2. A physician receives a request for a call to an established patient's parent to provide results of recent diagnostic tests. The physician telephones the parent and spends 5 minutes advising that the test results were within reference range and that no further testing is indicated. This service is not a **98016** service but rather is postservice work of a prior E/M service at which the tests were ordered. Had the call included an E/M service beyond provision of test results (eg, clinically indicated E/M of an unresolved or new problem) and more than 10 minutes of medical discussion, the service might be reported as an audio-only E/M service (**98008–98015**).
3. The parent of an established patient requests an audio-video E/M service with a nurse practitioner to discuss a possible reaction to an antibiotic prescribed to the patient at a visit with the nurse practitioner 3 days ago. The nurse practitioner obtains history of mild non-bloody diarrhea and advises the parent to continue the antibiotics and instructions for appropriate home care for the diarrhea. The total time of medical discussion is 6 minutes. This visit is related to the visit within the previous 7 days and is not separately reported.

Key Takeaways

The brief communication technology-based visit is a service for the purpose of determining if a more extensive E/M service is indicated. In addition to the intention of the service, the following are requirements for reporting this service:

- Only established patients are eligible to receive the service.
- The service must be initiated by a request from the patient, parent, or caregiver.
- The service must include at least 5 minutes of medical discussion.
- Do not report the service when originating from a related E/M service within the previous 7 days or when the service leads to an E/M or a procedure within the next 24 hours or at the soonest available appointment.

CPT 2025: Audio-Video Telemedicine Visits

Article Highlights

This continues a series of articles on telemedicine code changes that will be implemented for services provided on and after January 1, 2025. This installment focuses on a subcategory of codes for telemedicine evaluation and management (E/M) services provided via synchronous audio-video communications technology. Topics include the following:

- Review of audio-video telemedicine codes **98000–98007**
- Assigned relative value units (RVUs)
- General instructions for reporting **98000–98007**
- Coding examples for audio-video telemedicine services

Review of Audio-Video Telemedicine Codes **98000–98007**

New audio-video telemedicine service codes **98000–98007** are selected in the same manner as office or other outpatient E/M service codes **99202–99205** and **99212–99215**. No audio-video telemedicine code is equivalent to **99211** (office or other out-patient E/M of an established patient that may not require the presence of a physician or other qualified health care professional [QHP]). Codes **98000–98007** require a physician's or QHP's direct interactive communication with the patient and/or parent or caregiver using communications technology that includes both audio and video.

Audio-video telemedicine codes distinguish between services provided to new patients (**98000–98003**) and services provided to established patients (**98004–98007**). Table 1 introduces these new codes based on whether the patient is new or established. Full code descriptors are included in "*CPT 2025:* An Overview of Telemedicine Code Changes" in the November 2024 *AAP Pediatric Coding Newsletter*™ (available online at https://publications.aap.org/codingnews).

Table 1. 2025 Audio-Video Telemedicine Codes

Service description: Synchronous audio-video visit for the E/M of a new or established patient which requires a medically appropriate history and/or examination and either MDM or total time as indicated herein. When selecting a code based on total time, the minutes in the code descriptor must be met or exceeded. See full code descriptors in your 2025 *CPT* reference.

New Patient			Established Patient		
Code	Level of MDM	Total time[a]	Code	Level of MDM	Total time[a]
#●98000	Straightforward	15 min	#●98004	Straightforward	10 min
#●98001	Low	30 min	#●98005	Low	20 min
#●98002	Moderate	45 min	#●98006	Moderate	30 min
#●98003	High	60 min	#●98007	High	40 min

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

[a] When codes are selected based on total time, report prolonged E/M service (**99417**) in addition to **98003** or **98007** when the total time exceeds that required in the code descriptor by 15 minutes or more.

The following are notable characteristics of the audio-video telemedicine codes:

- Each service includes a medically appropriate history and/or examination.
- Each code is selected based on either the level of medical decision-making (MDM) or the physician's or QHP's total time spent in activities directly related to the care of the individual patient on the date of service.
  - As with other E/M codes that may be selected based on total time, the time in the code descriptor must be met or exceeded to support code selection.
- Prolonged outpatient E/M service (**99417**) may be reported in addition to either **98003** or **98007** when the code is selected based on total time and total time exceeds that required for the base service by at least 15 minutes.

Telemedicine modifier **95** is not applicable to the audio-video telemedicine codes.

Assigned Relative Value Units

Table 2 includes the work, total non-facility, and facility RVUs assigned to **98000–98007**. The RVUs included in the table are unadjusted for geographic locality and a hypothetical conversion factor of $40 per RVU is used to illustrate monetary values.

The audio-video codes are assigned less total RVUs than office visit codes **99202–99215** due to lower practice expense to provide the service (eg, reduced clinical staff time). The work RVUs assigned to **98000–98006** are equal to that of corresponding codes **99202–99214**. However, the work RVUs for **98007** are lower than **99215** (2.60 vs 2.80) and equal to **99204** (2.60) based on information obtained from physician surveys.

Table 2. 2025 Audio-Video Telemedicine Relative Value Units

RVUs are unadjusted for geographic locality. Payments may vary based on locality and contractual monetary conversion factors.

Code	Work RVUs	Non-facility RVUs	Monetary Value[a]	Facility RVUs	Monetary Value[a]
98000	0.93	1.54	$61.60	1.35	$54.00
98001	1.60	2.54	$101.60	2.33	$93.20
98002	2.60	4.05	$162.00	3.78	$151.20
98003	3.50	5.39	$215.60	5.09	$203.60
98004	0.70	1.20	$48.00	1.02	$40.80
98005	1.30	2.08	$83.20	1.88	$75.20
98006	1.92	3.08	$123.20	2.81	$112.40
98007	2.60	4.07	$162.80	3.78	$151.20

Abbreviation: RVU, relative value unit.

[a] Monetary values shown are based on a conversion factor of $40. Contracted rates may vary.

General Instructions for Reporting **98000–98007**

The instructions for reporting **98000–98007** are similar to those for office and other outpatient E/M services.

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- Visits may be initiated by the patient/caregiver or by the reporting physician or QHP (eg, recommended follow-up visit for an established patient).
- The level of MDM for a service is the level at which 2 of 3 elements of MDM (number and complexity of problems addressed, amount and/or complexity of data to be reviewed and analyzed, and/or risk of complications and/or morbidity or mortality of patient management) are met.
- Total time is only the physician's or QHP's time spent in activities that require the physician or other QHP and does not include time in activities typically performed by clinical staff such as time spent establishing the connection or arranging the appointment. (See *Current Procedural Terminology* [*CPT*®] E/M guidelines for activities included in total time.)
- Unlike digital E/M services (**99421–99423**), there is no required time interval between the last in-person or telemedicine visit and the current visit.
- When connections are lost during an audio-video visit and the service is completed with only an audio component, report the service that accounted for the majority of time spent in interactive discussion or patient observation (ie, either the audio-video service or an audio-only service [**98008–98015**]).

Audio-video telemedicine services may be provided on the same date as another E/M service or during the service period of another service. The following is guidance for reporting audio-video telemedicine services provided in conjunction with other services:

- Do not report an audio-video service when another E/M service (eg, in-person visit) is provided to the same patient by the same physician or QHP or by another physician or QHP of the same specialty and same group practice on the same date. Instead, report a single code for the combined MDM elements or total time of the services provided on the same date.
- When the same patient receives separate audio-video E/M services from physicians or QHPs of the same group practice but distinct specialties or subspecialties (eg, general pediatrician and cardiologist in a multispecialty group), each service is individually reported.
- Do not separately report an audio-video E/M service that is provided during the postoperative period of a related procedure performed by the same physician or QHP. Follow payer instructions for reporting **99024** (postoperative visit) when provided via telemedicine.

TIP

Append modifier **24** (unrelated E/M service during the postoperative period of a procedure) to the code for an audio-video visit to address an unrelated problem during the postoperative period of a procedure performed by the same physician or QHP.

- Do not separately report the initial visit that is included in a transitional care management service.
- Do not count the time of telemedicine services toward the time of other services such as care plan oversight, chronic care management, or principal care management.

CODING EXAMPLES FOR AUDIO-VIDEO TELEMEDICINE

The following examples are intended to demonstrate appropriate use of audio-video telemedicine codes and related coding instructions. These examples are not intended to offer advice on the practice of medicine. Additionally, code assignment must be based on the individual service provided and documented. See Table 3 to review the required level of MDM and total time for each code.

Table 3. Audio-Video Telemedicine Code Quick Reference

Total times must be met or exceeded.		
New Patient		
Code	**Level of MDM**	**Total Time**
#●98000	Straightforward	15 min
#●98001	Low	30 min
#●98002	Moderate	45 min
#●98003	High	60 min
#●98003, **99417**	≥75 min, +1 unit per ≥15 min	
Established Patient		
Code	**Level of MDM**	**Total Time**
#●98004	Straightforward	10 min
#●98005	Low	20 min
#●98006	Moderate	30 min
#●98007	High	40 min
#●98007, **99417**	≥55 min, +1 unit per ≥15 min	

Abbreviation: MDM, medical decision-making.

1. A physician provides a new patient visit to a child who is referred for follow-up of an exacerbated chronic condition that recently required hospitalization. History includes the request by the patient's parents for a telemedicine visit due to inability to take time off work after days spent at the hospital during their child's recent inpatient stay. The physician spends *25 minutes* on the date of the visit reviewing the patient's medical records shared by the patient's primary pediatrician and also test results in the patient's hospital record. Another *30 minutes* is spent evaluating the patient via secure audio-video telemedicine technology including obtaining history from the patient's parents and a limited examination. The patient's parents agree with the physician's plan for managing the child's condition and comorbidities. After spending *15 minutes* entering orders for prescription drugs and documenting the service, the physician's total time directed to the care of the patient is

70 minutes. Elements of MDM of the service include the following:

- Problem addressed: *moderate*—a chronic condition that is not stable
- Data reviewed and analyzed: *moderate*—review of records from 2 external sources and requirement for an independent historian (Category 1 data)
- Risk: *moderate*—prescription drug management and a social determinant of health related to parent's inability to miss work to bring the child to appointments

All 3 elements support moderate MDM and **98002**. However, the code reported is **98003** based on the total time of 70 minutes. Had the time met or exceeded 75 minutes, **99417** would be reported in addition to **98003**.

2. An established patient is scheduled for a follow-up visit to review the effectiveness of a medication prescribed 1 month ago for management of a chronic condition. At the parent's request the visit is provided via audio-video telemedicine with the child's grandmother who provides after-school care. History is obtained from the child and the child's grandmother supporting improvement without adverse effects. An assessment of improved control of symptoms of the chronic condition and a plan for continuing the current medication as prescribed is documented. Total time spent by the physician is 15 minutes. Elements of MDM of the service include the following:
   - Problem addressed: *low*—a stable chronic condition
   - Data reviewed and analyzed: *limited*—requirement for an independent historian (Category 2 data)
   - Risk: *moderate*—prescription drug management

   Code **98005** is reported based on the low level of MDM. The total time of 15 minutes supports **98004**, but the higher of the level of MDM or total time determines code selection.
3. An audio-video telemedicine service is scheduled for a new patient whose home is a 2-hour drive from the hematologist/oncologist's office and children's hospital. The patient is referred for management of newly diagnosed lymphoma that is expected to require inpatient treatment. This initial visit is focused on review of the patient's medical history including history obtained from parents and treatment planning. Although the visit begins with audio-video communication, the connection fails after 20 minutes and, when reconnected, only the audio component is available for the final 15 minutes of medical discussion. The physician's total time of 70 minutes on the date of the encounter includes pre-visit review of medical records from a recent hospital stay, independent interpretation of recent imaging studies, and post-visit documentation of the visit, orders for 3 unique tests, and a treatment plan including hospital admission the following week. Elements of MDM of the service include the following:
   - Problem addressed: *high*—an acute or chronic illness or injury that is a threat to life or bodily function
   - Data reviewed and analyzed: *high*—review of records from an external source, orders for 3 tests, and requirement for an independent historian (Category 1 data) and independent interpretation of images (Category 2 data)
   - Risk: *high*—decision for drug therapy requiring intensive monitoring for toxicity and hospital admission

   Because the time spent in audio-video communication exceeded the time that was limited to audio-only communication, the appropriate audio-video E/M service code is reported. Code **98003** is supported by the high level of MDM and also the total time of 70 minutes. The required total time for **98003** is 60 minutes. Had the total time on the date of service met or exceeded 75 minutes, prolonged service code **99417** would be reported in addition to **98003** when reporting the service based on total time. If the time spent in audio-only communication had exceeded that of the audio-video portion of the service, a code for an audio-only service (ie, **98011**, audio-only telemedicine, ≥60 minutes or high-level MDM) would be reported.

Key Takeaways

Although the change from use of an E/M code with modifier **95** to use of codes that are specific to audio-video E/M services is significant, the coding concepts should be familiar to most physicians and QHPs with experience selecting E/M codes based on MDM or total time. Remember these points when reporting audio-video E/M services.

- Codes **98000–98007** require a physician's or QHP's direct interactive communication with the patient and/or parent or caregiver using communications technology that includes both audio and video.
- Telemedicine modifier **95** is not applicable to the audio-video telemedicine codes.
- Visits may be initiated by the patient/caregiver or by the reporting physician or QHP (eg, recommended follow-up visit for an established patient).
- Each code is selected based on either the level of MDM or the physician's or QHP's total time spent in activities directly related to the care of the individual patient on the date of service.
- When connections are lost during an audio-video visit and the service is completed with only an audio component, report the service that accounted for the majority of time spent in interactive discussion or patient observation (ie, either the audio-video service or an audio-only service).

CPT 2025: Audio-Only Telemedicine Services

Article Highlights

This article provides guidance for reporting audio-only telemedicine services provided on and after January 1, 2025. The following topics are included:

- Codes for audio-only telemedicine services
- Assigned relative value units (RVUs)
- General instructions for reporting **98008–98015**
- Examples: coding audio-only telemedicine services

A new category of codes for audio-only telemedicine services (**98008–98015**) has been introduced following deletion of telephone evaluation and management (E/M) service codes **99441–99443**. Codes **98008–98015** are effective for dates of service on and after January 1, 2025, and are significantly different in terms of utilization and code selection requirements.

TIP

See codes **98966–98968** for reporting telephone assessment and management services provided by nonphysician qualified health care professionals whose scope of practice does not include E/M services (eg, licensed clinical social workers, clinical psychologists).

Codes for Audio-Only Telemedicine Services

Audio-only telemedicine services are reported based on whether the patient is new (**98008–98011**) or established (**98012–98015**) to the reporting physician or other qualified health care professional (QHP). *Current Procedural Terminology* (*CPT*®) defines a new patient as one who has not received a professional service from the same physician or QHP or from another physician or QHP of the same specialty and subspecialty practicing in the same group practice (reporting the same tax identification number) in the 3 years prior to the date of service.

Either the level of medical decision-making (MDM) or total time spent on the date of service by the reporting physician or QHP is used to determine the level of service provided. Table 1 provides the required levels of MDM or total time for each code.

All levels of audio-only E/M service *must include more than 10 minutes of medical discussion*. Regardless of whether code selection is based on MDM or total time, if 10 minutes or less of medical discussion take place, the service is not reported with **98008–98015**.

Full code descriptors are included in "*CPT 2025:* An Overview of Telemedicine Code Changes" in the November 2024 *AAP Pediatric Coding Newsletter*™ (available online at https://publications.aap.org/codingnews).

Time of Medical Discussion

CPT defines medical discussion as synchronous (real-time) interactive verbal communication regarding a patient's health care needs. The time of medical discussion is a distinct component of the total time on the date of the encounter. Other time devoted to the patient's care on the date of an E/M visit (eg, reviewing external data or coordinating care) is included in the total time of service. When reporting **98008–98015**, document the time of medical discussion and, when applicable, the total time on the date of the visit (eg, total time of 25 minutes including 15 minutes in medical discussion).

When an audio-only service with 10 minutes or less of medical discussion is provided to an *established patient*, consider whether the criteria for reporting a brief communication technology-based E/M service (**98016**) has been met (eg, at least 5 minutes of medical discussion). Code **98016** cannot be reported for a new patient service.

Table 1. 2025 Audio-Only Telemedicine Codes

Service description: Synchronous audio-only visits for the E/M of a new or established patient that require a medically appropriate history and/or examination, *more than 10 minutes of medical discussion*, and either MDM or total time as indicated herein. When selecting a code based on total time, the minutes in the code descriptor must be exceeded for **98012** (>10 minutes) and met or exceeded for other audio-only codes. See full code descriptors in your 2025 *CPT* reference.

New Patient			Established Patient		
Code	**Level of MDM**	**Total Time**	**Code**	**Level of MDM**	**Total Time**
#●98008	Straightforward	15 min	**#●98012**	Straightforward	11 min
#●98009	Low	30 min	**#●98013**	Low	20 min
#●98010	Moderate	45 min	**#●98014**	Moderate	30 min
#●98011	High	60 min	**#●98015**	High	40 min
#●98011, **99417**	≥75 min +1 unit per ≥15 min		**#●98015**, **99417**	≥55 min +1 unit per ≥15 min	

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

Assigned Relative Value Units

The RVUs assigned to the audio-only telemedicine codes are shown in Table 2. The RVUs in this table are unadjusted for geographic locality and the monetary conversion factor used is a hypothetical $40 per RVU.

Table 2. 2025 Audio-Only Telemedicine Relative Value Units

RVUs are unadjusted for geographic locality. Payments may vary based on locality and contractual monetary conversion factors.					
Code	**Work RVUs**	**Non-facility RVUs**	**Monetary Value[a]**	**Facility RVUs**	**Monetary Value[a]**
98008	0.90	1.46	$58.40	1.29	$51.60
98009	1.55	2.42	$96.80	2.24	$89.60
98010	2.42	3.77	$150.80	3.53	$141.20
98011	3.20	4.91	$196.40	4.64	$185.60
98012	0.65	1.10	$44.00	0.95	$38.00
98013	1.20	1.90	$76.00	1.73	$69.20
98014	1.75	2.78	$111.20	2.56	$102.40
98015	2.60	4.04	$161.60	3.78	$151.20

Abbreviation: RVU, relative value unit.

[a]Monetary values shown are based on a conversion factor of $40. Contracted rates may vary.

General Instructions for Reporting **98008–98015**

Because each audio-only code is described as inclusive of more than 10 minutes of medical discussion, documentation should support that the time spent in medical discussion is *11 minutes or more*. When the service includes 11 minutes or more of medical discussion, code selection is based on either total time or MDM in the same manner as codes for office and other outpatient E/M services.

Audio-only telemedicine visit guidelines also include the following:

- Telemedicine modifier **93** is not applicable to the audio-only telemedicine codes.
- Do not report an audio-only visit when another visit (eg, in-person visit later on the same date) is provided to the same patient by the same physician or QHP or another physician or QHP in the same specialty and same group practice on the same date.
- Prolonged E/M service (**99417**) may be reported in addition to either **98011** or **98015** when the code is selected based on total time and total time exceeds that required for the base service by at least 15 minutes.
- Services may be initiated by either the physician or QHP (eg, scheduled follow-up visit) or the patient and/or parent or caregiver.
- There is no required time interval between the last in-person or telemedicine visit and the current audio-only visit.
- Audio-only telemedicine services include those provided via a telecommunication technology device for the deaf.

Do not separately report a related audio-only visit when any of the following are applicable:

✖ The service is provided during the postoperative period of a procedure performed by the same physician or QHP.

✖ An established patient service (**98012–98015**) is provided during the service period of complex chronic care management (**99487**, **99489**) or transitional care management (**99495**, **99496**).

✖ The audio-only E/M service time is also attributed to another service (eg, chronic care management [**99437**, **99491**] or principal care management services [**99424**, **99425**] personally performed by a physician or QHP).

EXAMPLES: CODING AUDIO-ONLY TELEMEDICINE SERVICES

The following examples are intended only to illustrate application of codes and coding instructions. They are not intended to offer advice on the practice of medicine. Additionally, code assignment must be based on the individual service provided and documented. See Table 3 to review the required level of MDM and total time for each code. The scenarios in the examples include services that would or would not be reported as audio-only telemedicine services.

1. A physician who is personally providing chronic care management services (**99491**, **99437**) to a patient provides an audio-only E/M service to the patient's parents, who have questions about a new option offered by a subspecialist for managing one of their child's chronic conditions and how the new option may affect management of the child's other conditions. The physician spends 5 minutes prior to the call reviewing the subspecialist's recommendations and then 15 minutes discussing the benefits and risks of the proposed management option in the context of the child's overall health and psychosocial needs. The physician's total time on the date of service is 30 minutes, with 15 minutes spent in medical discussion, supporting **98014**. The physician's time spent on the date of the audio-only E/M service is not included in the time of the separately reported chronic care management service.
2. At the request of a new or established patient's mother, a physician speaks with the mother by audio-only communication technology about symptoms the patient developed overnight, including cough and shortness of breath. The mother is advised to bring the patient to the physician's office for evaluation later that morning. Only the in-person visit is reported. The time and MDM of the audio-only service is combined with that of the in-person visit later that day and contributes to code selection.
3. A physician provides a telephone E/M service to an established patient whose mother is concerned that her child may need to be seen due to diarrhea that began overnight. Based on the mother's description of the onset of illness and the child's symptoms, the physician recommends care at home. The mother is given instructions regarding symptoms that should prompt another call to the office. The physician's total

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time of medical discussion on the call is 8 minutes. The service does not meet the requirements of an audio-only telemedicine service, which includes more than 10 minutes of medical discussion. However, new code **98016** (brief communication technology-based service, 5–10 minutes) may be reported provided that the patient has not received a related E/M service within the previous 7 days and does not receive an E/M service or procedure within the next 24 hours or soonest available appointment. (See "*CPT 2025:* Reporting a Brief Communication Technology-Based Service" elsewhere in this newsletter.)

4. A telephone visit is provided by a nurse practitioner at the request of the parent of a new patient seeking advice on whether an office visit is appropriate. After the parent has provided new patient demographic information to clinical staff, the nurse practitioner spends 5 minutes speaking with the patient's mother and advises that the patient be taken immediately to an emergency department (ED) for suspected ingestion of a button battery. The nurse practitioner's total time on the date of the service is 15 minutes, but the service is non-billable because the time of medical discussion was not longer than 10 minutes to support an audio-only telemedicine visit (eg, **98008**) and no further E/M service is provided in the nurse practitioner's office on this date. Brief communication technology-based service code **98016** would also not apply to a service to a new patient.
5. A physician or QHP provides an audio-only E/M service to an adolescent established patient with complex health care needs including type 1 diabetes, celiac disease, and anxiety. The patient expresses increased anxiety due in part to disagreements with his mother related to alarm settings of the patient's continuous glucose monitoring system and increased social activities that require eating away from home. The physician reviews recommended alarm settings with the patient and his mother as well as addressing other factors increasing the patient's anxiety. The physician's documented time of medical discussion is 40 minutes and the total time on the date of service is 55 minutes. Code **98015** (first 40 minutes) and prolonged service code **99417** × 1 unit (additional 15 minutes) are reported based on the total time of 55 minutes that included 11 minutes or more of medical discussion.
6. A physician provides a scheduled visit to a new patient who was referred by the ED following a visit for exacerbation of asthma over the weekend. On the day of the visit, the physician reviewed the ED visit record and had clinical staff contact the patient's parents to schedule a follow-up visit. Due to transportation difficulty and limited internet access, the patient's parents requested a telephone visit. The visit includes history obtained from the patient and parents and a plan for identifying asthma triggers, logging symptoms, and continuing prescribed medications. Diagnosis is asthma with exacerbation. The management plan includes a follow-up visit in 2 weeks at an office site closer to the patient's home with inclusion of a same-date routine child health examination. The level of MDM supported by the documentation is moderate and the total time of service is 35 minutes *including 15 minutes in medical discussion.* Code **98010** is reported based on the moderate level of MDM supported by the problem addressed (asthma with exacerbation) and risk of management (prescription drug management) and 11 minutes or more of medical discussion.

Table 3. Audio-Only Telemedicine Code Quick Reference

All levels of service require 10 minutes or more of medical discussion. Listed total times must be met or exceeded.

New Patient		
Code	**Level of MDM**	**Total Time**
#●98008	Straightforward	15 min
#●98009	Low	30 min
#●98010	Moderate	45 min
#●98011	High	60 min
#●98011, **99417**	≥75 min, +1 unit per ≥15 min	
Established Patient		
Code	**Level of MDM**	**Total Time**
#●98012	Straightforward	11 min
#●98013	Low	20 min
#●98014	Moderate	30 min
#●98015	High	40 min
#●98015, **99417**	≥55 min, +1 unit per ≥15 min	

Abbreviation: MDM, medical decision-making.

Key Takeaways

When reporting audio-only E/M services provided in 2025, keep these points in mind.

- Audio-only telemedicine services are reported based on the status of the patient to the reporting physician or QHP, either new (**98008–98011**) or established (**98012–98015**).
- Either the level of MDM or total time spent on the date of service by the reporting physician or QHP is used to determine the level of service provided.
- An additional requirement for all levels of audio-only E/M service is that *the service must include more than 10 minutes of medical discussion.* Regardless of code selection based on MDM or total time, if 10 minutes or less of medical discussion takes place, the service is not reported with **98008–98015**.
- When an audio-only service that does not include more than 10 minutes of medical discussion is provided to an established patient, consider whether the criteria for reporting a brief communication technology-based E/M service (**98016**) has been met.
- Prolonged E/M service (**99417**) may be reported in addition to either **98011** or **98015** when the code is selected based on total time and total time exceeds what is required for the base service by at least 15 minutes.

Updated Reporting for 2024–2025 COVID-19 Vaccines

Article Highlights

This article provides information about codes for reporting the provision and administration of COVID-19 vaccines for the 2024–2025 season, including codes by product and age indication.

Current Procedural Terminology® codes **91304** and **91318–91322** reported for COVID-19 vaccines during the 2023–2024 season are still applicable for reporting in the 2024–2025 season. Report **90480** (immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease (COVID-19)]) vaccine, single dose) for administration with or without counseling by a physician or other qualified health care professional (QHP). Code **90480** is valued similarly to **90460** (immunization administration through 18 years of age via any route of administration, with counseling by physician or other QHP; first or only component of each vaccine or toxoid administered) with 0.25 work relative value units (RVUs) and 0.70 total non-facility RVUs (unadjusted for geographic locality; based on RVUs proposed for the 2025 Medicare Physician Fee Schedule).

National Drug Codes (NDCs), required by some payers, are changed for each of the 2024–2025 products. Follow payer-specifications for reporting the NDC from either the outer or inner packaging for the product administered. Immunization product packaging typically includes 10-digit NDCs that must be converted to 11 digits in a 5-4-2 format prior to reporting. The Table includes NDCs in the 11-digit format. To verify current NDCs, see the National Drug Code Directory published by the US Food and Drug Administration at https://dps.fda.gov/ndc.

Dig Deeper

See the most up-to-date COVID-19 vaccine coding resources at www.aap.org/coding. Also see the AAP Immunization Coding Table (https://downloads.aap.org/AAP/PDF/coding_vaccine_coding_table.pdf) for a listing of codes for reporting provision of other recommended pediatric immunization products and immunization administration. For more information on reporting immunization services, see *Coding for Pediatrics 2025*, Chapter 8, "Preventive Services" (www.aap.org/shopaap-coding).

COVID-19 Vaccine Codes and National Drug Codes 2024–2025

Report *CPT* codes for COVID-19 vaccine products in addition to administration code **90480** (immunization administration by IM injection of SARS-CoV-2 [COVID-19] vaccine, single dose). Link to diagnosis code **Z23** (encounter for immunization). NDCs are shown in the required 5-4-2 reporting format.

Manufacturer/ Product	Age Group	*CPT* Code	NDC Outer Packaging	NDC Inner Packaging
Novavax (EUA)	≥12 y	**91304** SARS-CoV-2 (COVID-19) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for IM use	10 1-dose syringes **80631-0107-10**	1-dose syringe **80631-0107-01**
Pfizer-BioNTech (EUA)—yellow caps and labels with yellow borders	6 mo–4 y	**91318** SARS-CoV-2 (COVID-19) vaccine, mRNA-LNP, spike protein, 3 mcg/0.3 mL dosage, tris-sucrose formulation, for IM use	10 3-dose vials **59267-4426-02**	3-dose vial **59267-4426-01**
Pfizer-BioNTech (EUA)—blue caps and labels with blue borders	5–11 y	**91319** SARS-CoV-2 (COVID-19) vaccine, mRNA-LNP, spike protein, 10 mcg/0.3 mL dosage, tris-sucrose formulation, for IM use	10 1-dose vials **59267-4438-02**	1-dose vial **59267-4438-01**
Pfizer-BioNTech Comirnaty	≥12 y	**91320** SARS-CoV-2 (COVID-19) vaccine, mRNA-LNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for IM use	10 1-dose syringes **00069-2432-10** 10 1-dose vials **00069-2403-10**	1-dose syringe **00069-2432-01** 1-dose vial **00069-2403-01**
Moderna (EUA)	6 mo–11 y	**91321** SARS-CoV-2 (COVID-19) vaccine, mRNA-LNP, 25 mcg/0.25 mL dosage, for IM use	10 1-dose syringes **80777-0291-80** 5 sets of 2 (10), 1-dose syringes **80777-0291-81**	1-dose syringe **80777-0291-09**
Moderna Spikevax	≥12 y	**91322** SARS-CoV-2 (COVID-19) vaccine, mRNA-LNP, 50 mcg/0.5 mL dosage, for IM use	10 1-dose vials **80777-0110-95** 10 1-dose syringes **80777-0110-96** 5 sets of 2 (10), 1-dose syringes **80777-0110-93**	1-dose vial **80777-0110-04** 1-dose syringe **80777-0110-01**

Abbreviations: *CPT, Current Procedural Terminology;* EUA, emergency use authorization; IM, intramuscular; NDC, National Drug Code.

You can earn 0.5 continuing education units from the American Academy of Professional Coders (AAPC) by completing this quiz with a score of 80% or better. Only this newsletter is required to complete the quiz, and you may retake the quiz as often as needed. Simply take the quiz and then visit https://publications.aap.org/codingnews to enter your answers online and collect your certificate.

0.5 Continuing Education Units

1. **Which is true for 98016 (brief communication technology-based service) but not for audio-only evaluation and management (E/M) services reported with 98008–98015?**
   a. Services may be initiated by either the patient and/or caregiver or by a physician or other qualified health care professional (QHP).
   b. Services must be initiated by the patient and/or caregiver.
   c. There is no required time interval between the last in-person or telemedicine visit.
   d. Either total time or medical decision-making (MDM) may be used in code selection.

2. **Which is the time requirement for the brief communication technology-based service reported with 98016?**
   a. 10 minutes of total time on the date of service
   b. 10 minutes of medical discussion
   c. 5 to 10 minutes of medical discussion
   d. Time is not a required element for **98016**.

3. **Which statement accurately describes the use of time in selecting audio-video telemedicine codes 98000–98007?**
   a. Time spent establishing the connection or arranging the appointment is included in the physician's or QHP's total time of service.
   b. Prolonged service code **99417** cannot be reported in conjunction with **98000–98007**.
   c. Total time is only the physician's or QHP's time spent in activities requiring a physician or other QHP.
   d. Codes **98000–98007** are selected based on only the time spent in medical discussion and examination.

4. **How is the description of time required to support time-based billing of 98012 (level 1 established patient audio-only visit) different from that of codes 98008–98011 and 98013–98015?**
   a. The total time of 10 minutes must be exceeded to report **98012**, whereas total time for the other audio-only codes must be met or exceeded.
   b. The required time of medical discussion is lower for **98012** than **98008–98011** and **98013–98015**.
   c. Billing based on total time is not an option for **98012**.
   d. Only **98012** requires more than 10 minutes of medical discussion.

5. **Which of the following statements is true of *Current Procedural Terminology*® guidelines for reporting 98000–98015 for telemedicine E/M services provided in 2025?**
   a. All E/M services provided by telemedicine in 2025 will be reported with **98000–98015** regardless of the site of service (eg, hospital, emergency department).
   b. Code selection is only based on the time spent in medical discussion.
   c. Either MDM or total time may be used in code selection provided other requirements for the specific code are met.
   d. Modifiers must be used to indicate the place of service as home or other site when reporting **98000–98015**.