



Telehealth

INTRODUCTION

In the evolving healthcare landscape, telehealth services have emerged as a vital and flexible solution for providing patient care. This coding paper provides guidance on the various modes of conducting telehealth services, including CPT and CDT coding options. AAOMS advises OMSs to refer to CPT and CDT coding books and guidance published by CMS, AMA and ADA for appropriate coding for telehealth services. Coverage policies and billing procedures related to telehealth services vary among payers. Therefore, OMSs are encouraged to confirm benefits and billing protocols with each payer prior to submitting claims and review managed care contract terms prior to balance billing patients. Lastly, the ability for an OMS to perform telehealth services varies by state. Therefore, it is each OMS's responsibility to confirm such services are within the scope of his or her license(s) as directed by the state Dental Practice Act and/or state Medical Practice Act.

DEFINITION

HHS defines telehealth as the use of electronic information and telecommunication technologies to extend care when a patient and doctor are not in the same place at the same time.

Telemedicine is the practice of medicine using technology to deliver care at a distance and, similarly, teledentistry is the use of information technology and telecommunications for dental care, consultation, education, public awareness and communication between dental or medical providers regarding care of a mutual patient. Some benefits to using telehealth services may include:

- Reduced office traffic.
- Increased patient convenience.
- Limiting exposure for at-risk patients or those with certain underlying health conditions (e.g., insulin-dependent diabetes mellitus, obesity, immunosuppression, pulmonary disease).

- Expanded accommodation for postoperative visits for routine, minimally invasive procedures.
- Screening consults.

HOW TELEHEALTH IS RENDERED

Both teledentistry and telemedicine may be rendered via video, audio or virtual check-in using a phone or device with internet. Modes are often referred to as synchronous or asynchronous:

- **Live video chat (synchronous)** – live, two-way interaction between a person (patient, caregiver or provider) and a provider using audiovisual telecommunications technology.
- **Store-and-forward (asynchronous)** – transmission of radiographs, photographs, video or digital impressions through a secure electronic communications system to a practitioner. This information is then used to diagnose or provide a service.
- **Remote patient monitoring (RPM)** – collecting personal health and medical data from a single individual via electronic medical device technologies. The data are transmitted to a different location (sometimes via a data processing service) where the provider can access the data for monitoring conditions and supporting care delivery.
- **Mobile health (mHealth)** – healthcare education, practice and delivery done over mobile communication devices, such as cellphones, tablet computers and personal digital assistants.

Currently, AAOMS does not offer a telehealth service recommendation. However, OMSs may wish to follow up with their own software vendor, which may have the capability to conduct telehealth services. OMSVision, for example, has reported adding a telehealth feature to its software.

Questions to consider when using software: How is protected health information (PHI) handled? What equipment is needed? Is there a waiting room feature? Does the software allow for scheduling appointments

and obtaining consent? Will the patient need to download an application or software to utilize the service?

What services may be rendered via telehealth

Telehealth may prove to be an efficient method to triage patients to determine if their condition is urgent or emergent and warrants an in-person visit. It also can be useful when providing a quick check-in or for conducting a postoperative visit.

Telehealth visits may be conducted over the phone, digitally via face-to-face or even interpersonal. Some OMSs have reported they are seeing initial consultations for single-tooth extractions, biopsy pre-ops and non-complicated third molar cases when an adequate radiograph is provided by the referring dentist. The OMS workflow during such telehealth visits may include pre-op instructions, risks, benefits, treatment alternatives and scheduling.

AAOMS recommends contacting commercial payers to verify services covered via telehealth. A list of services payable under the Medicare Physician Fee Schedule (MPFS) when furnished via telehealth can be found on the CMS website at [CMS.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

CODING/DOCUMENTATION FOR TELEHEALTH SERVICES

Several CPT and CDT codes may be reported for conducting virtual evaluations and/or treatment advice to patients.

It is imperative to review complete coding guidance in CPT and CDT coding books prior to using telehealth codes because of their specific guidelines.

It also is imperative the mode of telehealth used is documented, including the duration of the telehealth visit. In some instances, payers will allow coverage for traditional evaluations rendered via telehealth. However, keep in mind the components/criteria of these typical evaluations must still be met; therefore, documentation must support the service reported and billed.

TELEDENTISTRY CODING

For services rendered using telecommunication technology to triage patients or to determine if the situation is urgent or emergent, the following CDT codes may be used to document and report:

D0140 limited oral evaluation – problem focused

Coding Paper



- D0170 re-evaluation – limited, problem focused (established patient; not post-operative visit)
- D0171 re-evaluation – post-operative office visit
- D0190 screening of a patient
- D0191 assessment of a patient
- D0999 unspecified diagnostic procedure, by report
- D9992 dental case management – care coordination
- D9995 teledentistry – synchronous; real-time encounter
Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service
- D9996 teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review
Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service

Note: The ADA's Guide to Understanding and Documenting Teledentistry Events provides additional information on D9995 and D9996 and is available on their website at [ADA.org/publications/CDT/coding-education](https://www.ada.org/publications/CDT/coding-education).

Sample scenarios

OMS screens a patient using audio means only	D0190 or D0999
OMS provides a problem-focused evaluation using audio and visual means	D0140 or D0170 and D9995 or D9996
Triage call center forwards a patient to an OMS who provides a problem-focused evaluation using asynchronous audio and visual means	Call Center: D0190 or D0999 OMS: D0140 or D0170 and D9995
General dentist or OMS forwards a patient to a different specialist who provides a problem-focused evaluation using information that is stored and forwarded	General dentist/OMS: D0190 or D0999 Specialist: D0140 or D0170 and D9996

TELEMEDICINE CODING

CMS recognizes three types of virtual medical services:

- Telehealth visits
- Virtual check-ins/online digital visits
- E-visits

Telehealth visits (99202-99215)

Telehealth visits are visits between a physician and a patient using telecommunication systems.

AAOMS strongly recommends reviewing chapter guidelines in the CPT coding book prior to reporting E/M and other telehealth visit codes. For example, as of Jan. 1, 2021, [new guidelines](#) for office and other outpatient E/M services were implemented, allowing selection of the level of service to be based on one of the following:

- The level of medical decision making (MDM) as defined for each service.
- The total time for E/M services performed on the date of the encounter.

For 2023, the updated guidelines for office and other outpatient E/M services were [extended](#) to hospital inpatient and observation visits, consultations and services in the emergency department. It is important to note that specific to emergency department levels of E/M services, time is not used in code selection but rather is based only on MDM. In general, these changes were adopted by CMS, also effective as of 2023.

Further changes, effective Jan. 1, 2024, include the removal of time ranges from descriptors for office or other outpatient codes 99202-99205 and 99212-99215. These codes now include a time (in minutes) that must be met or exceeded in order to report the code when total time on the date of the encounter is used for code selection.

Effective Jan. 1, 2025, a new suite of codes was added to the CPT code set to report telemedicine office visits which include eight codes for synchronous audio-video services (98000-98003 and 98004-98007), eight codes for synchronous audio-only services (98008-98011 and 98012-98015) and one code for an asynchronous service (98016). CPT code 98016 describes a brief virtual check-in encounter, which replaces HCPCS code G2012 (*Brief communication technology-based service*).

Coding Paper

These new codes are patterned after the in-person office visit codes with subsets for new patients and established patients and may be reported based on the level of medical decision making or total time on the date of the encounter. In addition to these new codes, CPT codes for telephone E/M services 99441, 99442 and 99443 have been deleted.

Medicare has given 16 of the 17 new codes a status indicator of invalid (I), which means the code is not valid for payment. The only new code Medicare will allow reimbursement for is the virtual check-in code, CPT code 98016.

AAOMS advises OMSs and their coding and billing staff to check third-party payer policies to determine eligibility for reimbursement for telemedicine services.

Refer to the 2026 CPT coding manual to review all revisions and guidelines. You also may find the most updated guidance at AMA-assn.org.

If the telehealth visit does not meet the components of a traditional E/M service, the following codes listed under the subheadings Online Digital E/M services and Virtual Check-ins may apply. However, CPT guidelines restrict the use of these codes if a face-to-face visit took place or will take place within a certain number of days of the telehealth visit. Please refer to CPT guidelines for details on reporting these types of services to ensure appropriate code use.

Online digital E/M services (99421-99423)

Online digital E/M services are conducted through an online patient portal and initiated by the patient. These CPT codes may be used when rendering a digital evaluation for an established patient who initiated the digital evaluation by sending the OMS a message detailing his or her concerns via a patient portal, secure email or other HIPAA-compliant electronic communication. These services are not for the nonevaluative electronic communication of test results, scheduling of appointments or other communication that does not involve an E/M. These codes may be reported only once for the doctor's cumulative time over a seven-day period.



CPT code	Description
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	11-20 minutes
99423	21 or more minutes

Virtual check-ins (G2251, G2252)

Virtual check-ins are brief check-ins with an established patient via the phone or other telecommunication device to determine whether an office visit is needed. CMS confirms virtual services should be initiated by the patient. However, practitioners may need to inform beneficiaries of the service prior to patient initiation. Similar to online digital e-visits, these codes are not reported for communicating test results or scheduling appointments.

HCPCS code	Description
G2251	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management 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.
G2252	11-20 minutes of medical discussion.

Virtual check-in services as described by G2251 and G2252 may be furnished using several communication technology modalities. This includes audio-only real-time telephone interactions as well as more advanced options such as patient portals or HIPAA-compliant video services.

OTHER FORMS OF COMMUNICATION

Interprofessional telephone/internet/electronic health record consultations (99446-99452)

An interprofessional consultation via telephone, internet or EHR is an assessment and management service in which the patient's treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a physician with specific specialty expertise to assist the treating provider in the diagnosis and/or management of the patient's problem without face-to-face contact with the consultant. CPT codes 99446-99451 should be used by the consulting physician or other qualified healthcare professional to report their services. For these codes, the interprofessional consultation can be requested for a patient who is either new to the consultant, or an existing patient experiencing a new issue or exacerbation of a current problem. In order to report an interprofessional consultation service, the consultant must not have had a face-to-face encounter with the patient in the past 14 days. Additionally, these codes cannot be used if the interprofessional consultation leads to transfer of care or another face-to-face service (e.g., hospital visit, surgery, scheduled in-person evaluation) within the next 14 days or next available appointment date.

CPT codes 99446-99451 should not be reported more than once in a 7-day period.

CPT code 99452 may be reported by the treating/requesting physician or other qualified healthcare professional when 16-30 minutes are spent in a service day preparing for the referral and/or communicating with the consultant. 99452 may not be reported more than once in a 14-day period and cannot be reported with a same-day E/M service.

Coding Paper



CPT code	Description
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447	11-20 minutes of medical consultative discussion and review
99448	21-30 minutes of medical consultative discussion and review
99449	31 minutes or more of medical consultative discussion and review
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

Emergency department or inpatient telehealth consultations (G0425-G0247, G0406-G0408)

The following HCPCS codes may be used to report emergency department or inpatient telehealth consultations (initial and follow-up) for Medicare beneficiaries:

HCPCS code	Description
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth

Coding Paper



Per CMS guidelines, the purpose of telehealth consultations in the emergency department or inpatient settings is for a physician or qualified nonphysician practitioner to seek insights from another clinician. This request is made for advice, opinions, recommendations, or guidance in patient evaluation or treatment, based on the consulted individual's specialized medical expertise that extends beyond the requesting professional's knowledge base. Since 2010, CMS does not recognize office/outpatient or inpatient consultation CPT codes for payment; however, Medicare will permit payment for emergency department or inpatient telehealth consultations when all Medicare policy criteria are met.

When selecting the appropriate code for the telemedicine service, it is imperative the OMS documents the mode utilized as well as the duration of the service. In addition, telehealth rules do not apply when the beneficiary and the practitioner are in the same location, even if audiovisual technology assists in furnishing a service. Keep in mind that reporting requirements, coverage and payment for telehealth services can vary by carrier. For example, Medicare's telehealth policy includes an "originating site" or the location where a Medicare beneficiary receives medical services through a telecommunications system.

CMS provided a range of telehealth waivers and flexibilities due to the PHE, which included temporary easing of geographic and originating site restrictions. While these flexibilities were set to expire Dec. 31, 2024, the American Relief Act of 2025 extended these flexibilities through March 31, 2025. These flexibilities were further extended through Dec. 31, 2027, following Congressional action. More information can be found at [CMS.gov/files/document/telehealth-faq-updated-02-04-2026.pdf](https://www.cms.gov/files/document/telehealth-faq-updated-02-04-2026.pdf).

In addition, CMS clarified definitions for the following:

Audio-Only Communication: For any Medicare telehealth service furnished to a beneficiary in their home, an interactive telecommunications system may include two-way, real-time, audio-only communication technology if the patient is not capable of or does not consent to the use of video technology

Virtual Direct Supervision: The policy allowing supervising physicians or practitioners to provide direct supervision via real-time audio and visual interactive telecommunications has been made permanent for certain services.

Provider resources, including Medicare telehealth policy updates and billing guidance are available at [Telehealth.HHS.gov/providers/telehealth-policy](https://www.hhs.gov/providers/telehealth-policy).

Medicaid telehealth reimbursement policies vary state to state. Many states now allow telehealth services via telephone, electronic and virtual means, home as originating site and coverage and payment parity for telehealth services. Because each policy is state-specific, OMSs participating in the Medicaid program should contact their state agency for current reporting and payment protocols. Visit [Medicaid.gov/medicaid/benefits/telehealth/index.html](https://www.medicaid.gov/medicaid/benefits/telehealth/index.html) for more details.

Further, commercial medical payers may have their own individual billing rules regarding reporting and payment. Therefore, it is advised to confirm each payer's policy guidelines prior to submitting claims.

Place of Service codes and telehealth modifiers

Reporting telehealth services may require indicating to the payer where the provider and the patient are located during the telehealth encounter. This is done using the appropriate Place of Service (POS) code:

POS 02: The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

POS 10: The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

CPT also has specific modifiers to append to the E/M visits to indicate the type of telehealth service that took place:

Modifier –93: Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System



Appendix T in the CPT code book includes a complete list of codes that may be used for reporting audio-only services when appended by modifier –93. These codes are identified in the CPT code book with the “speaker” symbol.

- ◄ Identifies codes that may be used to report audio-only telemedicine services when appended by modifier –93.

Modifier –95: Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System

Appendix P in the CPT code book includes a complete list of codes that may be used for reporting synchronous (real-time) interactive audio-video telemedicine services when appended by modifier –95. The codes are identified in the CPT code book with the “star” symbol.

- ★ Identifies codes that may be used to report audio-video telemedicine services when appended by modifier –95.

HCPCS telehealth service modifiers include:

Modifier –GQ: Via an asynchronous telecommunications system

Modifier –GT: Via Interactive Audio and Video Telecommunication Systems

Note: According to CMS, modifier –GT is no longer required on professional claims for Medicare telehealth services and should only be used on institutional claims billed by critical access hospitals.

According to CPT, the standards and requirements for exchanging information between the healthcare provider and the patient should be the same, regardless of whether the service is delivered through telemedicine or in a traditional face-to-face setting. In other words, the telemedicine service must be equivalent to a face-to-face service.

Additionally, CPT guidelines indicate the benefit of providing the service using telemedicine instead of face-to-face must be clear. For example, telemedicine services may facilitate a diagnosis or treatment plan that may reduce complications, decrease in-person visits to the emergency department or enhance access to care, particularly for rural and vulnerable patients.

Reporting requirements for POS codes and modifier use in telehealth services vary by payer. For example, effective January 1, 2024, CMS requires providers to report the

appropriate POS code (either POS 02 or POS 10) for Medicare telehealth service claims, without the use of modifier –95. However, CMS has specified that modifier –95 is still necessary in certain situations. For instance, when a clinician provides telehealth services from a hospital to a beneficiary at their home, the appropriate hospital POS code should be used along with modifier –95.

Although some payers may not require modifiers to identify telehealth services, they may still be accepted as informational if reported on claims with eligible telehealth services. As reporting guidance and reimbursement policies for telemedicine vary across the industry, it is recommended to confirm with each payer individually on the use of modifiers and/or POS codes prior to claim submission.

Matters to discuss with patients regarding the use of a teleconferencing platform:

- Confirm the patient has used videoconferencing before and, if not, offer a practice meeting with a staff member.
- Provide instructions/tips to the patient (be alone if privacy is preferred, good lighting, functional microphone and speakers, retraction available, reliable internet connection, etc.).
- Discuss how long should be allotted for the telehealth visit.
- Notify if other staff members will participate in the teleconference.
- Explain the pre-appointment process prior to the meeting (online registration, insurance breakdown, referral received, consent, etc.).
- Notify whether the teleconference will be recorded by the provider or the patient.
- Inform of use of a digital background (Zoom).
- Discuss how consent will be obtained.
- Create an email template to include patient education materials, telehealth consent, etc., along with the videoconference invitation link (unless a website-based platform will be used).

Coding Paper



- Notify of when will patients be informed of the charges associated with the telehealth consult and will they be charged for the in-person exam.
- Discuss what occurs if the insurance does not pay for the telehealth consult.
- Discuss what is the plan if there are technical problems during or preventing the scheduled telehealth consultation. Note: In the event of a disruption in the virtual connection, the encounter would be suspended until connection resumes or the appointment is rescheduled, and documentation should reflect the occurrence.

CONSENT FOR TREATMENT VIA TELEHEALTH

The OMS is still expected to obtain and document a patient's consent for conducting services via telehealth. Some practices are utilizing patient portals within their EHRs, email or options such as DocuSign to have patients sign all consent forms virtually. If the patient is treated in the office and the follow-up visit is scheduled to be rendered via telehealth, it is best to have the patient sign the consent when he or she is in the office.

SAMPLE DOCUMENTATION

Document the following:

- Clearly state communication was via telecommunication.
- The platform used: e.g., Zoom, BlueJeans, MouthWatch
- The method of telecommunication:
 - Audio only
 - Audio and video
- Patient consent (dated)
- Whether recording of the conversation is or is not authorized
- Date and time of service
- Reason for the appointment
- Chief complaint

- Past medical history/review of systems
- Synopsis of visual findings
- Assessment
- Plan:
 - Labs, orders, radiology
 - Referrals
 - Follow-up
- Documentation of the time spent on the call

PAYER COVERAGE

Telehealth service policies continue to evolve. One constant is the varying coverage and reimbursement among different insurers, including federal and third-party payers.

Providers should review their contracts with all payers to determine whether the patient may be billed in the event a claim is denied. Additionally, telehealth regulations, including teledentistry, differ by state. It is important for OMSs to confirm with state dental and medical boards to determine if/when appropriate to render telehealth services in the practice.

ADDITIONAL RECOMMENDATIONS

Consult with a liability carrier such as the [OMS National Insurance Company \(OMSNIC\)](#) regarding telemedicine consent forms and additional documentation required for a telemedicine/telehealth/teledentistry consultation.

Information on HIPAA and telehealth privacy and security, including guidance on communication technologies utilized to furnish telehealth services, is available at [HHS.gov](#).

AAOMS also published the [AAOMS White Paper on Telehealth and Remote Treatment](#).

Coding Paper



Note: The list of CDT and CPT codes in this coding paper is not all-inclusive. AAOMS recommends reporting codes applicable to the service(s) rendered and the patient's specific clinical condition as determined by the provider.

This paper should not be used as the sole reference in coding. Both diagnosis and treatment codes change frequently, and insurance carriers may differ in their interpretations of the codes.

Coding and billing decisions are personal choices to be made by individual oral and maxillofacial surgeons exercising their own professional judgment in each situation. The information provided in this paper is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by anyone in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, professional advisers should be consulted.

Current Dental Terminology (CDT) © 2025 American Dental Association. All rights reserved.

Current Procedural Terminology (CPT) © 2025 American Medical Association. All rights reserved..

CDT is a registered trademark of the American Dental Association.

CPT is a registered trademark of the American Medical Association.

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery. This paper discusses procedural coding guidelines utilizing CPT, HCPCS and CDT. When indicated, reference the appropriate area of the coding books where the principles of coding illustrated in this paper may be applied.

Proper coding provides a uniform language to describe medical, surgical and dental services. Diagnostic and procedure codes are regularly updated or revised. The AAOMS Committee on Healthcare Policy, Coding and Reimbursement has developed these coding guidelines to assist the membership in using the coding systems effectively and efficiently.

© 2026 American Association of Oral and Maxillofacial Surgeons. No portion of this publication may be used or reproduced without the express written consent of the American Association of Oral and Maxillofacial Surgeons.

Revised January 2026