

# Telehealth Services Coding Guide

Last revised: May 2026



## Purpose

The purpose of this guide is to establish proper use of telehealth/telemedicine codes under Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), Oregon Health Authority (OHA), and CareOregon guidelines.

CMS telehealth coverage requirements are subject to frequent and significant revisions as federal policy changes occur. Organizations are encouraged to routinely monitor CMS rulemaking, federal legislation, and official updates to ensure ongoing compliance with current telehealth billing, documentation, originating site requirements and service eligibility.

## Scope

This applies to all providers that submit claims for services via telehealth. Communication may be between providers, multiple providers and one or more clients or members, family members, caregivers, and guardians.

## Telehealth policy

Telemedicine services are synchronous, real-time, interactive encounters between a physician or other qualified healthcare professional (QHP)

Telehealth services include audio/video, video-only, audio-only, and asynchronous (store and forward) services.

Privacy and security standards for telehealth must be met prior to the delivery of services using any mode of telecommunication. A member's written, oral, or recorded consent to receive services, in the language that the member understands, must be obtained and documented by the health system, clinic, or provider in the member's health record.

There is no limitation on the location of the member. The OHP-enrolled provider may be in any location where member privacy and confidentiality can be ensured. All services rendered using a telehealth platform must comply with Health Insurance Portability and Accountability Act (HIPAA).

Providers who offer telehealth services must:

- Hold an unencumbered Oregon license
- Be enrolled with the Authority as an Oregon Health Plan (OHP) provider per OAR 410-120-1260
- Provide services that are within their licensing board's scope of practice

To determine if the service is covered as a telehealth service, please consult Ancillary Guideline A5, telehealth, teleconsultations and online telephonic services in the most current Oregon Prioritized List of Health Services. On the Oregon Health Authority page at [Prioritized List of Health Services](#).

## Place of service (POS)

All physical and behavioral health services (except School Based Health Services) must include place of service (POS) **02** when the member is in a place **other than their home**. When the member is **in their home**, the claim must include POS **10**.

## Modifiers

All claims for services rendered using telehealth must include modifiers to indicate the mode of communication. Modifier **95** indicates that the service was performed utilizing a real-time interactive **audio and video** telecommunications system. When the provision of services utilizes a real-time interactive **audio-only**, the claim must include modifier **93**. Modifier **GT** also continues to be an acceptable modifier for behavioral health telehealth services as well.

## Behavioral health telehealth services

OHA behavioral health (BH) fee schedules list modifier GT to denote that services were furnished via telehealth. If a behavioral health code does not have GT listed as an allowable modifier, it is not eligible for telehealth. Modifier GT does not explicitly distinguish whether the telecommunication modality consisted of audio-video or audio-only services. Pursuant to OAR 410-172-0850, behavioral health services are required to be covered irrespective of the telecommunication modality utilized. Accordingly, modifier GT is acceptable for billing behavioral health services.

## Evaluation and management services via telehealth

Evaluation and management (E/M) services are billable via telehealth. They can be billed using either traditional E/M codes with the appropriate place of service and modifier to indicate that the service was performed using telemedicine technologies. The level of service (LOS) can be selected using either time or medical decision making (MDM).

For synchronous audio-only telehealth E/M services (**CPT 98008–98015**), the encounter must include **more than 10 minutes of medical discussion** to be eligible for reporting these codes. This requirement functions as a **minimum threshold for code eligibility** and is **not an additional time requirement** beyond total E/M time. Once this threshold is met, the level of service is selected based on **MDM or total time**, as applicable.

Telehealth encounters that do not exceed 10 minutes of medical discussion do not meet the criteria for CPT codes 98008–98015 and may qualify instead for CPT **98016 (brief communication technology-based service)**, when all applicable requirements are satisfied.

The codes **98000-98015 are not covered by Medicare**, and providers should either use the appropriate E/M service provided via telehealth with the appropriate POS and modifier(s), or report **98016** for a brief communication technology-based service provided to an **established patient** by a physician or other QHP who can report E/M services.

Telemedicine services must be used to report services that are performed on a separate calendar date from another E/M service. If performed on the same date as another E/M service, the elements and time of these services are reported in aggregate to ensure that overlapping time is only counted once.

If the audio-video connections are lost during an encounter, and only audio is restored, report the service that accounts for the majority of the time of the interactive portion of the service.

Telemedicine should not be reported for communications related to a previous encounter (example: to communicate lab results).

## Documentation requirements

Prior to the delivery of telehealth services, a client or member's written, oral, or recorded consent to receive services via telehealth communication must be obtained and documented in the health record. The consent must include an assessment of the client or member's readiness to access and participate in telehealth services. Consent must be updated annually.

Telehealth services must be documented the same way as services that are rendered in person. The documentation must support:

- Medical necessity
- Assessment and treatment
- Services rendered

For telehealth encounters, documentation of medically necessary services must be clearly documented in the health record for the encounter date. **The documentation must include:**

- The mode of telecommunications used for the encounter (audio-video, audio-only, etc.)
- The time of the call, including start and stop times if the code selection is based on time, or the MDM that justifies the LOS selected. (For example, if billing an evaluation and management service in addition to 30 minutes of psychotherapy. The start and stop times of the service(s) rendered must be documented.)
- The location of the patient to justify the POS billed on the claim

## Definitions

**Asynchronous:** not simultaneous or concurrent in time. Asynchronous telecommunication for telehealth services may include audio and video, audio without video, client, or member portal and may include remote monitoring. It does not include voice messages, facsimile, e-mail, or text messages.

**Distant site:** The location where the physician or practitioner is physically located at the time they deliver a telehealth service through a telecommunications system.

**Evaluation and management:** (E/M) services professional services performed in the office. Traditional in-person office visit codes include 99202-99215.

**Originating site:** The location of the patient at the time the telehealth service is rendered.

**Telehealth:** Includes telemedicine and includes the use of electronic information and telecommunications technologies to support remote clinical, healthcare, client or member and professional health-related education, public health and health administration.

**Telemedicine:** the mode of delivering remote clinical health services using information and telecommunication technologies to provide consultation education or to facilitate diagnosis, treatment, care management or self-management

**Qualified Health Care Professional (QHP):** an individual that is qualified by training, education, licensure and/or regulation of any applicable license and/or facility privileging who performs a professional service within their scope of practice and independently reports that professional service. Examples include NP, PA, CNS, CNM, CSW, PT, etc.

## References

Oregon Secretary of State. OAR 410-120-1990: Telehealth. Retrieved from

<https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=324005>

Oregon Secretary of State. OAR 410-120-1260: Provider Enrollment. Retrieved from

<https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=310113>

Oregon Secretary of State. OAR 410-120-1360: Requirements for Financial, Clinical and Other Records.

Retrieved from <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=306657>

American Medical Association. (2025). CPT® 2026 Professional Edition. American Medical Association Publishing

Oregon Secretary of State. OAR 410-172-0850: Telemedicine for behavioral health. Retrieved from

<https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=246504>

Oregon Health Authority, Prioritized List, Ancillary Guideline A5, Telehealth, Teleconsultations and Online/Telephonic Services, <https://www.oregon.gov/oha/hpa/dsi-herc/pages/prioritized-list.aspx>

This document is provided for informational purposes only and should not be construed as legal advice. Any cited statutes are current as of the date of publication of this guide.

These guidelines have been developed to accompany and complement the official conventions and instructions provided within the American Medical Association's Current Procedural Terminology (CPT®) itself. Additions and deletions conform it to the most recent publications of CPT® and HCPCS Level II and to changes in CareOregon and its affiliates coverage policy and payment status, and as such these guidelines are current as of 01/01/2026. Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. CareOregon and its affiliates make no claim, promise, or guarantee of any kind about the accuracy, completeness, or adequacy of the content for a specific claim, situation, or provider office application, and expressly disclaim liability for errors and omissions in such content. As CPT® codes change annually, you should reference the current version of published coding guidelines and/or recommendations from nationally recognized coding organizations for the most detailed and up-to-date information.

CPT® is a registered trademark of the American Medical Association.

Copyright © American Medical Association. All rights reserved.