Telehealth FAQ Calendar Year 2025

Q1: Do Medicare beneficiaries need to be located in a rural area and in a medical facility in order to receive Medicare telehealth services?

A1: Pursuant to the American Relief Act, 2025, beneficiaries can continue to receive Medicare telehealth services wherever in the United States and territories they're located, including in their home, through March 31, 2025. They don't need to be in a rural area or a medical facility.

Q2: Are there any restrictions on the types of practitioners who can furnish Medicare telehealth services?

A2: Pursuant to the American Relief Act, 2025, through March 31, 2025, any practitioner who can independently bill Medicare for their professional services may furnish telehealth. This includes physical therapists, occupational therapists, speech-language pathologists, and audiologists.

Q3: Can outpatient therapy, diabetes self-management training and medical nutrition therapy services be furnished remotely by hospital staff to beneficiaries in their homes ?

A3: As we explained in the CY 2025 OPPS/ASC final rule with comment period, we have generally aligned payment policies for outpatient therapy services, diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services furnished remotely by hospital staff to beneficiaries in their homes with policies for Medicare telehealth services. We noted in the CY 2025 OPPS/ASC proposed rule that, to the extent therapists and DSMT and MNT practitioners continue to be distant site practitioners for purposes of Medicare telehealth services, we anticipated aligning our policy for these services with policies under the Physician Fee Schedule (PFS) and continuing to make payment to the hospital for these services when furnished by hospital staff. When the CY 2025 OPPS/ASC final rule was issued, the flexibility to allow an expanded range of practitioners to be eligible to furnish Medicare telehealth services, which included physical therapists (PTs), occupational therapists (OTs), and speech language pathologists (SLPs), was set to expire at the end of CY 2024. Consequently we stated that we would no longer pay for outpatient therapy, DSMT, and MNT services when furnished remotely by hospital staff to beneficiaries in their homes beginning in CY 2025, but we also noted that continuing to align our policies for outpatient therapy, DSMT, and MNT services when furnished by hospital staff with the Medicare telehealth policies that apply when these services are billed by the same clinicians but in private practice ensures clarity and consistency for providers and beneficiaries.

The American Relief Act, 2025 extended the expansion of the types of practitioners eligible to furnish Medicare telehealth services through March 31, 2025, thus enabling PTs, OTs, and SLPs to continue furnishing telehealth services through that date. CMS is continuing to align our requirements for payment for services furnished remotely by hospital staff to beneficiaries in their homes, including remotely furnished outpatient therapy services, DSMT, and MNT services, with requirements for Medicare telehealth services. Therefore, through March 31,

2025, hospitals can continue to bill for these services when furnished remotely by hospital staff to beneficiaries in their homes.

Q4: How does CMS make payment for telehealth services furnished in RHCs and FQHCs? Can Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) continue to serve as distant sites for the provision of telehealth services?

A4: Any behavioral health service furnished by an RHC or FQHC on or after January 1, 2022 through interactive telecommunications technology is paid under the All Inclusive Rate (AIR) and Prospective Payment System (PPS), respectively. Through March 31, 2025, RHCs and FQHCs may continue to bill for non-behavioral health services furnished through interactive telecommunications technology by reporting HCPCS code G2025 on the claim.

Q5: Will in person visit requirements apply to behavioral health services furnished by professionals through Medicare telehealth? What about behavioral health services furnished remotely by hospital staff to beneficiaries in their homes, or behavioral health visits furnished by RHCs, and FQHCs where the patient is present virtually?

A5: The American Relief Act, 2025 has delayed in-person visit requirements for behavioral health services for professionals billing for Medicare telehealth services until April 1, 2025.

Regarding behavioral health services furnished remotely by hospital staff to beneficiaries in their homes, we are continuing to align our policy with requirements for Medicare telehealth services billed under the PFS. Accordingly, we are also delaying the in-person visit requirements for these services until April 1, 2025.

In the CY 2025 PFS final rule, we finalized that for behavioral health visits furnished by RHCs and FQHCs where the patient is present virtually, we are delaying in-person visit requirements until January 1, 2026.

Q6: Can beneficiaries continue to receive audio-only telehealth services? Are audio-only telehealth services permitted in all originating sites?

A6:

Pursuant to the American Relief Act, 2025, physicians and practitioners may continue to use two-way, real-time audio-only communication technology for Medicare telehealth services furnished through March 31, 2025.

After March 31, 2025, physicians and practitioners may continue to use two-way, real-time audio-only communication technology to furnish Medicare telehealth services in accordance with the revised definition of “interactive telecommunications system”. In the CY 2025 PFS final rule, CMS permanently changed the definition of “interactive telecommunications system” to

include two-way, real-time audio-only communication technology for any telehealth service furnished to a patient in their home, provided that the furnishing physician or practitioner is technically capable of using audio-video communication technology and that the beneficiary is not capable of or does not consent to using audio-video communication technology. Audio-only can be used for both new and established patients. Beneficiaries who are receiving remote mental health services, as defined in the CY 2023 and 2024 OPPS Final Rules, furnished by hospital-employed staff in their homes may permanently receive these via audio-only communication technology.

Pursuant to the American Relief Act, 2025, audio-only telehealth services are permitted in all originating sites through March 31, 2025. However, in general, audio-only telehealth services are only permitted if the beneficiary is in their home. All other originating sites are medical facilities that generally have the infrastructure and broadband capacity to support two-way, audio/video communication technology. Additionally, patients would not have the same heightened expectation of privacy when video is used for a Medicare telehealth service in a medical facility as they would in their home.

Q7: What are the current guidelines for virtual presence for teaching physicians who furnish telehealth services involving residents?

A7: In the CY 2025 PFS final rule, we established that through December 31, 2025, we are continuing to allow teaching physicians to have a virtual presence in all teaching settings, but only for services furnished as a Medicare telehealth service. This will continue to permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought, through audio/video real-time communications technology, for all residency training locations through December 31, 2025.

Q8: Which place of service code should I use for telehealth services?

A8: Physicians and/or practitioners should use POS 02 for Telehealth Provided Other than in Patient's Home or POS 10 for Telehealth Provided in Patient's Home (which is a location other than a hospital or other facility where the patient receives care in a private residence). In the CY 2024 PFS final rule, we finalized that, starting January 1, 2024, claims for Medicare telehealth services provided to patients in their homes are to be paid at the non-facility payment rate.

Q9: Are there frequency limitations for subsequent inpatient and nursing facility visits and critical care consultations?

A9: In the CY 2025 PFS final rule, we established that through December 31, 2025, we are continuing to suspend the application of telehealth frequency limits on subsequent inpatient and nursing facility visits and critical care consultations.

Q10: Which services allow virtual direct supervision?

A10: For all services requiring direct supervision, we continue to permit direct supervision to be provided through real-time audio/video only through December 31, 2025. This applies to all services where direct supervision is required, including most incident-to services under § 410.26, many diagnostic tests under § 410.32, pulmonary rehabilitation services under § 410.47, cardiac rehabilitation and intensive cardiac rehabilitation services under § 410.49, and certain hospital outpatient services as provided under § 410.27(a)(1)(iv).In the CY 2025 PFS final rule, we finalized that for a certain subset of services valued under the PFS that are typically performed in their entirety by auxiliary personnel that are required to be furnished under direct supervision, we permanently adopted a definition of direct supervision that allows virtual presence through real-time audio and video communications technology.

Q11: Are there geographic or place of service restrictions for behavioral health telehealth services (including SUD services)?

A11: No. The Consolidated Appropriations Act, 2021 permanently removed geographic and place of service restrictions for behavioral health telehealth services. Beneficiaries, including those in both rural and urban areas, can receive behavioral health telehealth services in their homes. Two-way, interactive, audio-only technology is permitted for behavioral health telehealth services.

Q12: What does the “provisional” or “permanent” designation mean on the Medicare Telehealth Services List?

A12: In the CY 2024 PFS final rule (88 FR 78861 through 78866), we implemented a revised 5-step process for making additions, deletions, and changes to the Medicare Telehealth Services List (5-step process), beginning for the CY 2025 Medicare Telehealth Services List. Rather than categorizing a service as “Category 1” or “Category 2,” each service is now assigned a “permanent” or “provisional” status. A service is assigned a “provisional” status if available evidence does not yet demonstrate that the service is definitively of clinical benefit, but there is enough evidence to suggest that further study may demonstrate such benefit. The 5-step process review criteria are set forth in the CY 2024 PFS final rule (88 FR 78861 through 78866) and listed at https://www.cms.gov/medicare/coverage/telehealth/criteria-request.

Q13: Do services with a “provisional” designation expire each calendar year?

A13: No, there is no time limitation for services designated as “provisional” on the Medicare Telehealth Services List . We did not consider for CY 2025 whether to recategorize provisional codes as permanent because we intend to conduct a comprehensive evaluation of all Medicare telehealth services with provisional status. Services included on the Medicare Telehealth Services List with provisional status will remain on the list. We anticipate addressing these services in future rulemaking.

Q14: How do I request a change to the Medicare Telehealth Services List?

A14: Requests for changes to the Medicare Telehealth Services List must be received by CMS by February 10 of a year to be considered by CMS and addressed in PFS rulemaking for the following calendar year. Each request to add a service to the Medicare Telehealth Services List must include any supporting documentation the requester wishes us to consider as we review the request. Because we use the annual PFS rulemaking process to make changes to the Medicare Telehealth Services List, requesters are advised that any information submitted as part of a request is subject to public disclosure for this purpose. For more information on submitting a request to add or modify services on the Medicare Telehealth Services List, including where to send these requests, and to view the current Medicare Telehealth Services List, see our website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.

Q15: Why are non-face-to-face services (such as, but not limited to, Community Health Integration, Principal Illness Navigation, Chronic Care Management, Behavioral Health Integration, and Remote Monitoring) not on the Medicare Telehealth Services List?

A15: For these and similarly situated, non-face-to-face services, the telehealth restrictions are not applicable. Section 1834(m) of the Act limits payment for Medicare telehealth services to services that are in whole or in part, an inherently face-to-face service. Only services that serve as a substitute for an in-person encounter can be classified as a Medicare telehealth service. Services that do not require the presence of, or involve interaction with, the patient fall outside this definition. As discussed in prior rulemaking cycles, because these services do not serve as a substitute for an in-person encounter, we do not consider them to be Medicare telehealth services.