# Telehealth FAQ

Updated 2/4/26

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: Through December 31, 2027, beneficiaries can receive Medicare telehealth services anywhere in the United States and territories. Starting January 1, 2028, except for behavioral health services, beneficiaries will generally need to be in a medical facility and in a rural area to receive Medicare telehealth services.

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

A2: Through December 31, 2027, an extended range of practitioners may bill for Medicare telehealth services. Starting January 1, 2028, physical therapists, occupational therapists, speech-language pathologists, and audiologists can no longer furnish Medicare Telehealth services.

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: CMS is continuing to align payment policies for outpatient therapy services, diabetes self-management training and medical nutrition therapy services furnished remotely by hospital staff to beneficiaries with policies for Medicare telehealth services. Therefore, through December 31, 2027, hospitals may bill for these services. Starting January 1, 2028, hospitals may no longer 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 telecommunications technology is paid under the All Inclusive Rate (AIR) and Prospective Payment System (PPS), respectively. Through December 31, 2026, RHCs and FQHCs may continue to bill for non-behavioral health services furnished through

telecommunications technology by reporting HCPCS code G2025 on the claim. The home and any geographic location may continue to serve as a distant site and originating site for beneficiaries receiving telecommunications services furnished by RHCs and FQHCs.

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: Section 1834(m) of the Act requires an in-person, non-telehealth visit within 6 months prior to the first mental health telehealth service, effective after December 31, 2027. As was finalized in the CY 2022 PFS, payment for behavioral health services furnished through certain telecommunications technology while the patient is at home may be made only if the physician or practitioner has furnished an item or service in-person to the patient, without the use of telehealth, for which Medicare payment was made (or would have been made if the patient were entitled to, or enrolled for, Medicare benefits at the time the item or service is furnished) within 6 months prior to the initial telehealth service. After the first mental health telehealth service in the patient's home, there must be an in-person, non-telehealth service within 12 months of each mental health telehealth service—but to allow for limited exceptions to the requirement. These in-person visits may be performed by a physician or practitioner of the same specialty within the same group practice as the physician or practitioner who furnishes the telehealth service, if the physician or practitioner who furnishes the telehealth service is not available. While section 1834(m) of the Act requires an in-person, non-telehealth visit within 6 months prior to the first mental health telehealth service, we do not believe this requirement applies to beneficiaries who began receiving mental health telehealth services in their homes prior to January 1, 2028. In other words, if a beneficiary began receiving mental health services on or before December 31, 2027, then they would not be required to have an in-person visit within 6 months; rather, they will be considered established and will instead be required to have at least one in-person visit every 12 months. 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. For behavioral health visits furnished by RHCs and FQHCs where the patient is present virtually, in-person visit requirements will continue to not apply until at least until January 1, 2028.

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

A6: Under current law, beneficiaries may continue to receive audio-only telehealth services in their homes through December 31, 2027. Starting January 1, 2028, physicians and practitioners may use two-way, real-time audio-only communication technology for behavioral health services 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 also receive these services via audio-only communication technology.

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

A7: In the CY 2026 PFS final rule, we established that beginning January 1, 2026, 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.

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: No. In the CY 2026 PFS final rule, we permanently removed the application of telehealth frequency limits on subsequent inpatient and nursing facility visits and critical care consultations effective January 1, 2026.

Q10: Which services allow virtual direct supervision?

A10: In the CY 2026 PFS final rule, we finalized that, beginning January 1, 2026, the presence of the physician (or other practitioner) required for direct supervision may include virtual presence through audio/video real-time communications technology (excluding audio-only) for services without a 010 or 090 global surgery indicator. This applies to services where direct supervision is required that do not have a 010 or 090 global surgery indicator, 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).

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

A12: 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.

Q13: 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?

A13: 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. Services that do not serve as a substitute for an in-person encounter are not subject to the rules that apply to Medicare telehealth services.

Q14: What special telehealth flexibility applies to Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program?

A14: The Bipartisan Budget Act of 2018 allows clinicians in applicable Medicare Shared Savings Program Accountable Care Organizations (ACOs) to provide and receive payment for covered telehealth services to certain Medicare beneficiaries without geographic restriction and in the beneficiary's home. Physicians and practitioners participating in an applicable ACO may furnish telehealth services to beneficiaries assigned to the applicable ACO in accordance with these flexibilities. To receive payment for covered telehealth services under the special telehealth flexibilities for ACOs, the telehealth service must be billed through the TIN of an ACO participant in an applicable ACO. Applicable ACOs are those with prospective assignment for a performance year in the ENHANCED track or BASIC track levels C, D, or E. CMS allows clinicians in applicable ACOs to provide and receive payment for covered telehealth services to prospectively assigned beneficiaries. Risk-based ACOs that participate under the preliminary prospective assignment with retrospective reconciliation method do not meet the definition of an applicable ACO, because final assignment is not performed until after the end of the performance year. Clinicians in these ACOs and those in non-risk based ACOs may provide telehealth services subject to the current Medicare FFS rules. There is no special application or approval process for applicable ACOs or their ACO participants or ACO providers/suppliers. Clinicians in applicable ACOs can furnish and receive payment for covered telehealth services under these special telehealth flexibilities. For additional information, please refer to the Medicare Shared Savings Program Telehealth Fact Sheet and additional updates available at the All Fee-For-Service Providers webpage on CMS.gov.

Q15: Can distant site practitioners provide telehealth services from their home? Do practitioners need to report their home address on their Medicare enrollment application if they are providing telehealth services from home?

A15: Yes, practitioners can provide telehealth services from their home and in many cases do not need to report their home address. Practitioners who furnish telehealth services from their homes but have a physical practice location are not required to report their home address on their Medicare enrollment application. Practitioners can enroll and bill from their physical practice location as if they furnished the telehealth service in person. Virtual-only telehealth practitioners whose only physical practice location is their home address will need to enroll their home address as a practice location. The practitioner should mark the address as a "Home office for administrative/telehealth use only" location in their enrollment application to suppress the street address details from the practitioner's profile page on the CMS Care Compare Website, a tool for Medicare beneficiaries to find and compare different Medicare providers. The practitioner may also email the Quality Payment Program service center at QPP@cms.hhs.gov to suppress the street address and/or phone number from the page.

Q16: What will happen to telehealth services that were provided during the government shutdown?

A16: CMS will continue to pay telehealth claims in the same way they had been paid before October 1, 2025. Telehealth flexibilities will apply retroactively as if there hadn't been a temporary lapse in the application of the telehealth flexibilities.