

10/1 Update

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: After September 30, 2025, 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: After September 30, 2025, 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, after September 30, 2025, 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, 2025, RHCs and FQHCs may continue to bill for non-behavioral health services furnished through 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: Yes, 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 October 1, 2025.

In other words, if a beneficiary began receiving mental health services on or before September 30, 2025, 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. 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 at least 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: After September 30, 2025, physicians and practitioners may use 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 also receive services these 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 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 at least 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.

Q16: What special telehealth flexibility applies to Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program?

A16: 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.