Proposed CY 2026 MEDICARE PHYSICIAN FEE SCHEDULE

FACT SHEET I July 2025

On July 14, 2025, the Centers for Medicare and Medicaid Services (CMS) released their proposal for the 2026 Physician Fee Schedule (PFS). Each year, the agency uses the PFS to update, change or introduce new policies that will impact the Medicare program for the following year. Unless otherwise stated, the policies will typically go into effect the first of the year. What follows are the proposals that directly relate to telehealth. At this stage, these are only proposals and CMS is asking the public to provide comments on any item. The deadline to provide comments is September 12, 2025. Please note that the page numbers referenced below refer to the *unpublished version of the proposed 2026 PFS*.

Medicare Telehealth Services List: Revised Code Evaluation Process & Proposed Newly Eligible Services

(p.107)

CMS is proposing to alter their process regarding how they decide which services will be placed on the Medicare Telehealth Services List. Each year during the PFS process, CMS makes their own recommendations, as well as receives recommendations from the public, on which services should be added to the list. Each proposed service goes through a five-step evaluation process and CMS determines if the code should be denied from being on the list of eligible telehealth services in Medicare, or placed on the list in either a "permanent" or "provisional" status. The current five step process involves the following:

1. Determine whether the service is separately payable under the PFS.
2. Determine whether the service is subject to the provisions of section 1834(m) of the Social Security Act.
3. Review the elements of the service as described by the HCPCS code and determine whether each is capable of being furnished using an interactive telecommunications system as defined in 42 CFR § 410.78(a)(3).
4. Consider whether the service elements of the requested service map to the service elements of services that are on the list with a permanent status.
5. Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at a distant site using an interactive telecommunications system.

Within the CY 2026 PFS, CMS is proposing to eliminate Steps 4 and 5 to streamline the process and ease confusion regarding what is required for those who are interested in submitting proposed codes to be added to the Medicare Telehealth Services List. In its reasoning for the change, CMS stated, "We believe our proposed policy would allow patients and physicians or practitioners to determine the most appropriate service modality for an individual patient while continuing to ensure patient safety."

Additionally, within this revised process, the status of the code as either "permanent" or "provisional" would be eliminated. If the code makes it through the three-step process and is approved by CMS, it would be placed on the eligible telehealth services list as a "permanent" service, though CMS would retain the ability to remove the code at a future date based upon an internal review or feedback from

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the public. Since this is still just a proposal regarding the process and there currently exists codes in a "provisional" status on the Medicare Telehealth Services List, if the revised review process is adopted, the current "provisional" codes will essentially permanently remain on the eligible telehealth services list. If the proposal to change the review process is not adopted, CMS will conduct a comprehensive analysis of all current "provisional" status codes.

In addition to this procedural change, CMS is proposing the addition of certain codes and the deletion of one code currently on the Medicare Telehealth Services List.

CMS is proposing the deletion of HCPCS code G0136 coverage generally for Medicare, therefore including its removal from the Medicare Telehealth Services List. G0136 is the administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes. CMS writes that the resource costs described in G0136 are already accounted for in existing codes.

From the public, CMS received requests to add the following service codes to the Medicare Telehealth Services List:

HCPCS	SHORT DESCRIPTION
90849	Multiple family group psytx
G0473	Group behavioral counseling 2-10
G0545	Inherent Visit to inpt
92622 & 92623	Diagnostic analysis, programming and verification of an auditory osseointegrated sound processor
90935, 90937, 90945, 90947	Dialysis codes
98000 – 98015	Telemedicine E/M Codes
G0248	Demonstrate use home INR monitoring

CMS proposes to add 90849, G0473, G0545, 92622 and 92623 to the Medicare Telehealth Services List. CMS notes that based on their revised three-step process in evaluating which codes to add to the permanent list, these five codes pass the test.

CMS declined to add dialysis codes 90935, 90937, 90945, and 90947 due to insufficient information needed to determine if these codes would pass Step 3 in their evaluation. CMS was unclear on how telehealth would be used in providing these services and in which clinical circumstances the services would be furnished via telehealth.

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CMS is also declining to add G0248 to the list of eligible services because the service is not typically provided by a physician or a practitioner, but is a technical part of the service that is delivered by clinical staff connected to the supplier. CMS notes these types of services are severable from the professional services that the telehealth policies are meant to apply to and would not meet Step 2 in their review process.

CMS is also declining to add Telemedicine E/M codes 98000-98015 to the eligible telehealth services list, as it did in the 2025 PFS. These are the telemedicine codes created by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel in 2023. Within the 2025 PFS, CMS added 98016 to replace G2012. At the time, CMS noted that G2012 was not a code on the eligible telehealth services list as G2012 was a communication technology-based service (CTBS) code. Here, CMS makes a similar observation for 98000-98015, noting that they are not separately payable under the Medicare physician fee schedule when furnished in-person, and therefore would fail Step 1 of their review process. To be on the eligible telehealth services list, the code must also be one that is already being reimbursed by Medicare.

In a related clarification, CMS addressed questions it has received regarding Digital Mental Health Treatment (DMHT), Remote Physiologic Monitoring (RPM), and Remote Therapeutic Monitoring (RTM) services. CMS emphasizes that these services, which are inherently non-face-to-face, do not meet the statutory definitions for telehealth and therefore fall outside the scope of Medicare telehealth services. As such, they do not meet Step 2 of the review process and are not subject to the telehealth provisions under 1834(m).

CMS also writes that should anyone wish to submit codes for consideration to be added to the eligible telehealth services list for 2027, that submission deadline is February 10, 2026.

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Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

(P. 121)

CMS is proposing to permanently remove frequency limitations on the following codes:

HCPCS	SHORT DESCRIPTION
99231-99233	Subsequent Inpatient Visit CPT Codes
99307-99310	Subsequent Nursing Facility Visit CPT Codes
G0508 & G0509	Critical Care Consultation Services: HCPCS Codes

The frequency limitations were initially waived during the COVID-19 public health emergency (PHE) and were further suspended after the PHE ended. CMS stated that its analysis of claims data indicates the services are not currently being furnished via telehealth frequently enough to justify reimplementing limitations. Additionally, solicited comments from the public over the past two years have overwhelmingly supported permanently removing frequency limitations.

Direct Supervision via use of a Two-Way Audio-Video Communication Technology (p.127)

In previous iterations of the PFS, CMS has allowed for limited and temporary use of telehealth to meet direct supervision requirements. However, in the 2026 PFS, CMS is proposing to permanently adopt a definition for "immediate availability" of the supervising practitioner using audio-video real-time communication technology (audio-only is excluded) for all services described in 42 CFR Section 410.26 except for those services that have a global surgery indication (when some type of surgery occurred) of:

- **010** - Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable) or
- **090** - Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

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In the 2026 PFS, CMS is excluding the services in 010 and 090 to ensure quality of care and patient safety by not compromising the supervising practitioner's ability to intervene if complications arise. CMS is also seeking comment regarding applying the "immediate availability" definition to services that have a 000 global surgery indicator, as well as additional services under 42 CFR Section 410.32.

Direct Supervision of Residents (p. 132)

The current temporary policy allows for a teaching physician to have a virtual presence in all teaching settings, but in clinical instances, the virtual presence is allowed only when the services are furnished virtually. For the 2026 PFS, CMS believes this flexibility is no longer necessary. CMS is proposing to end this policy with the exception for services provided outside of a Metropolitan Statistical Area (MSA). "In these rural settings, teaching physicians may continue utilizing audio/video real-time communications technology to fulfill the presence requirement, provided they maintain active, real-time observation and participation in the service." Virtual supervision by teaching physicians for educational purposes may continue.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) (p. 468)

CMS proposes to extend for one additional year the ability for FQHCs and RHCs to bill for medical visit services (non-behavioral health services) provided via telecommunications technology, including those furnished via audio-only. FQHCs and RHCs would continue to use G2025 through December 31, 2026, and the payment amount will continue to be calculated based on the PFS and weighted by volume, not the FQHC/RHC's regular Prospective Payment System (PPS) rate or All Inclusive Rate (AIR). While CMS considered revisions that would allow medical visit services furnished via telecommunication technology to be paid at PPS/AIR rates, similar to allowances for mental health visits, they determined this route may lead to additional cost pressures. Nevertheless, they continue to solicit comments on the alternative payment proposal.

As a reminder, CMS made permanent the ability for FQHCs/RHCs to provide mental health visits via telecommunications technology in the 2022 PFS, if FQHCs/RHCs meet prior and subsequent in-person visit requirements. While the 2025 PFS delayed the in-person requirements for FQHCs/RHCs through the entirety of 2025, CMS notes that they will be updating that policy in the 2026 PFS consistent with federal statutory waivers of general telemental health in-person requirements, which currently only apply through September 30, 2025.

"CMS proposes to extend for one additional year the ability for FQHCs and RHCs to bill for medical visit services (non-behavioral health services) provided via telecommunications technology, including those furnished via audio-only."

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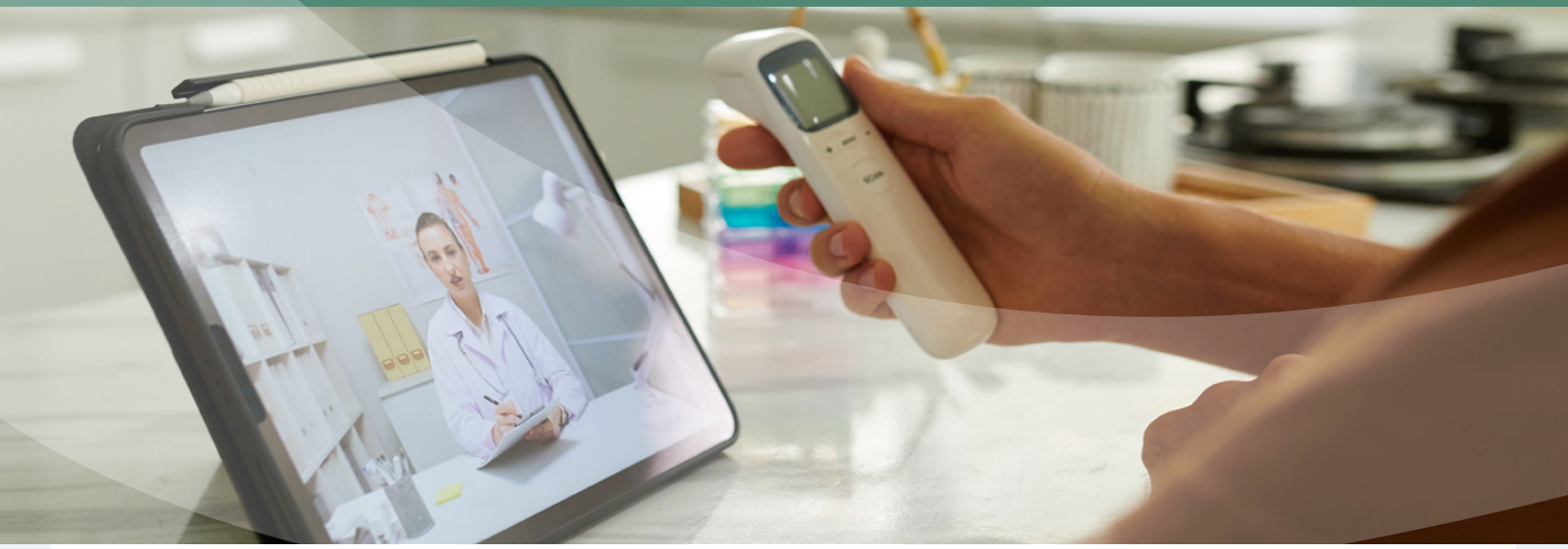

Advanced Primary Care Management (APCM) & Behavioral Health Integration/Collaborative Care Model (p. 452)

For Advanced Primary Care Management (APCM), CMS is proposing to adopt add-on codes that would facilitate Behavioral Health Integration (BHI) and Collaborative Care Model (CoCM) services for FQHCs and RHCs. In line with this proposed change, CMS is proposing to unbundle G0512. If the proposal is finalized, starting January 1, 2026, FQHCs and RHCs would no longer bill G0512 but instead use the CPT and HCPCS codes that make it up.

CODES THAT MAKE UP G0512	
HCPCS/CPT CODE	**SHORT DESCRIPTION**
99492	1st psych collab care mgmt.; CoCM First Month, 70 minutes per caledar month
99493	Sbsq psyc collab care management; CoCM Subsequent Months, 60 minutes per calendar month
99494	1st/subesq psyc collab care; Add-on CoCM (any month), each additional 30 minutes per calendar month.
G2214	Init/sub psych care m 1st 30; Initial or subsequent psychiatric collaborative care management, 30 minutes of behavioral health care manager time per calendar month.

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Payment for Communication Technology-Based Services (CTBS) and Remote Evaluation (p. 457)

CMS notes that APCM contains elements of CTBS and remote evaluation services. However, to this point CMS has not yet directed FQHCs and RHCs on how to avoid duplication of these services in their billing. Therefore, similarly to APCM, CMS proposes to require FQHCS and RHCs to report the individual codes that make up G0071 starting January 1, 2026. Payment for these services will be based on the non-facility PFS payment rate.

CTBS & REMOTE EVALUATION CODES TO USE	
HCPCS/CPT CODE	**SHORT DESCRIPTION**
G0071	Communication Services by RHC/FQHC 5 minutes
G2010	Remote image submit by patient
G2012	Discontinued - Brief check in by MD/QHP
G2250	Remote image submitted by patient, non-E/M
98016	Brief communication technology-based service

Other FQHC/RHC Related Proposals

- When proposals related to care management are finalized via the PFS, CMS is proposing to update FQHC/RHC policy through sub-regulatory guidance (bulletins, manual updates, etc.) rather than the full regulatory process. (p. 461)
- CMS is proposing to revise the definition of "direct supervision" so that the supervising physician or practitioner must be physically present at the FQHC or RHC site, but does not need to be in the same room as the service. Instead, they must be immediately available to provide assistance and direction, which can include being virtually present via real-time audio-video communication (but not audio-only). (p. 467)

"CMS is proposing to unbundle G0512. If the proposal is finalized, starting January 1, 2026, FQHCs and RHCs would no longer bill G0512 but instead use the CPT and HCPCS codes that make it up."

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Ambulatory Specialty Model (ASM) (p. 1387)

The Ambulatory Specialty Model (ASM) is a new model that would focus on low back pain and congestive heart failure. The goal of the model is to prevent worsening or reoccurrence of chronic conditions, and improve chronic disease management and early detection. CMS' overview of this model can be found in the Ambulatory Specialty Model factsheet. In this model, certain permanent Medicare telehealth policies would be waived, namely the geographic and site requirements.

Additional Proposals

- Telehealth originating site fee of $31.85 (p. 134)
- For Digital Mental Health Treatment (DMHT), CMS makes several clarifications regarding the requirements of the code, such as the patient must have a mental health condition diagnosis, but the billing practitioner does not need to be the practitioner who made the diagnosis. CMS is also proposing to expand their payment policies for G0552, G0553 and G0554 to make payment for DMHT devices that are cleared and classified under certain regulations for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). (p. 311)
- New codes have been created for both Remote Therapeutic Monitoring (RTM) and Remote Physiological Monitoring (RPM) for less than 16 days of data transmission per 30 day period and less than 20 minutes of interactive communication per month: 98XX4, 98XX5, and 98XX7 (RTM), 99XX4 and 99XX5 (RPM). (p. 229)
- Several definition changes to the Medicare Diabetes Prevention Program (MDPP) that would extend virtual delivery flexibilities through to December 31, 2029. (p. 1115)
- CMS is proposing to add coverage for asynchronous online delivery of MDPP through December 31, 2029. (p. 1117)

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Analysis

It should be noted that CMS is limited in what changes it can make in relation to telehealth policy in Medicare. Many of the broader, more wide-reaching policies, such as limitations on the location of the patient at the time of the telehealth interaction (though currently waived through September 30, 2025), are embedded in federal statute and require Congressional action. That is why certain policy waivers must be done through Congressional action and not through administrative channels like the PFS, and are therefore not present in these proposals.

Two of the main telehealth proposals in the 2026 PFS include the changes to the CMS review of proposed services for the Medicare Telehealth Services List, and the one-year extension for FQHCs and RHCs to provide medical services via telecommunications technology.

The first major proposal, the revised review process to add services to the eligible telehealth services list, is meant to streamline that process and make it easier for people submitting services to understand what is required. Additionally, CMS writes in regard to the proposal:

> *We continue to believe that physicians and other practitioners, given their in-depth knowledge of their beneficiaries' clinical needs, are best positioned to exercise their professional judgment in determining whether a service can be safely furnished via telehealth and whether furnishing a service via telehealth will provide clinical benefit justifying its use.*

This theme of empowering the provider to exercise their clinical judgement is found throughout several telehealth related sections in the proposed PFS.

The second big proposal includes extending for one-year an FQHC/RHC's ability to provide medical services via telecommunications technology. This extension provides time for Congress to enact any potential policies that might impact this scenario, for example making FQHCs and RHCs permanent eligible telehealth providers in Medicare. This policy is already in effect as CMS proposed and finalized it in the 2025 PFS. However, in that PFS CMS had solicited feedback in regard to whether it should change the definition of a medical visit for FQHCs and RHCs to include the ability to provide services via telecommunications technology. This is similar to what they had already done with the definition for a mental health visit as it applies to these entities. The mental health visit definition change is permanent policy and ensures FQHCs and RHCs receive their PPS or AIR rate for the provision of these services via telehealth. The proposal for medical visits is temporary (just through December 31, 2026) and would not pay at the PPS or AIR rate, but at a rate calculated based on the fee schedule. CMS again solicits feedback on this policy in the 2026 PFS, similar to the 2025 PFS,

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but appears to have remaining and unaddressed fiscal concerns preventing them from making the allowance permanent at this time.

One permanent change that many telehealth advocates have been asking for that is included in the proposed PFS for 2026 is eliminating frequency limits for SNF, inpatient and critical care visits. Over the last few years CMS has consistently made adjustments to these frequency limitation policies, each time broadening the policy, and we now see in the 2026 PFS they are proposing to eliminate them completely. An incremental approach to policy expansions is noted as preferred by CMS throughout various sections of the proposals.

Missing from the 2026 proposed PFS is a policy to extend the allowance for distant site providers to use their practice location instead of their home address when enrolling to provide Medicare telehealth services from the home. The address reporting allowance was in the final 2025 PFS, but it makes no appearance here. Telehealth providers, citing privacy and safety concerns given that reporting information can be accessible by the public, have long requested that accommodations be made to protect telehealth providers' home address information. Without any extension proposal, this allowance will end January 1, 2026.

Comments are due to CMS by September 12, 2025:

Electronic Submissions:
Federal Register

Regular Mail:
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Department of Health and Human Services,
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