Center for Connected Health Policy | THE NATIONAL TELEHEALTH POLICY RESOURCE CENTER

Medicare Waiver Expiration & Telehealth FAQs

The expiration of the Medicare telehealth waivers on September 30, 2025, has created significant uncertainty for providers as longstanding flexibilities have been scaled back or altered. While Congress continues to negotiate a government funding package that may reinstate some of these flexibilities, permanent statutory restrictions are now in effect layered with CMS guidance that is at times ambiguous or unclear. As a result, providers are facing complex questions regarding in-person visit requirements, billing procedures, and the applicability of policies across different care settings. This FAQ document is designed to address the most common questions CCHP has received through its technical assistance channels since October 1, 2025, and to highlight where CMS has offered clear direction, and where gaps remain.

MENTAL HEALTH

Do I need to conduct a new in-person visit for behavioral health patients who were established via telehealth before the new Medicare requirements took effect?

This has been one of the most common questions since the Medicare in-person requirement officially went into effect on October 1, 2025 for behavioral health telehealth services. The short answer is: it depends—and unfortunately, CMS hasn't provided a definitive answer yet.

Here's what we *do* know:

- CMS addressed this in 2023: In the 2023 Physician Fee Schedule (PFS), CMS said that for patients already receiving mental/behavioral health services via telehealth during the Public Health Emergency (PHE) and in the 151 day period proceeding it, a new *initial* in-person visit within six months wasn't required. Instead, those patients would just need to comply with the ongoing annual in-person visit requirement.
- Post-PHE period is unclear: CMS has not clarified whether that same rule will carry forward for established patients post-October 1, 2025. Therefore, it's unclear whether providers must treat the first post–Oct. 1 visit as a brand-new telehealth start (which would require an in-person visit within the preceding 6 months), or whether those who have been receiving services all along are exempt from that "initial" requirement and just need to comply with the annual in-person visit rule.
- What to consider: If CMS *does* consider the first visit on or after October 1 to be the "initial telehealth visit," then to meet the prior six-month in-person visit requirement, the patient would have needed to have had an in-person visit between March 30 and September 30, 2025 if the telehealth visit occurred on Oct. 1, 2025 (and that date window moves forward every day to accommodate for six month time period). However, CMS has historically leaned toward

continuity of care, and based on their thinking in the 2023 PFS, they may consider these patients as already established.

- Annual in-person visit exception still applies: Even if CMS decides to grandfather in existing patients and exempt them from the 6-month prior in-person visit requirement, the annual in-person visit would still apply, meaning an in-person visit must be on record in the twelve months preceding the first telehealth visit on or after October 1, 2025, unless the patient and provider agree that the burdens of coming in-person outweigh the benefits. If so, that determination must be documented in the medical record.
- CMS may issue further guidance: CMS announced it is holding claims for a 10-day period (Oct 1–10) while Congress negotiates a potential waiver extension, so more clarity may be coming. Until then, we recommend providers document everything clearly in the patient record and check with their Medicare Administrative Contractor (MAC) if they have concerns.

How do I document the exception for the annual in-person mental health visit when the risks or burdens outweigh the benefits?

Under Medicare's current policy for mental and behavioral health services delivered via telehealth, providers are required to conduct an in-person visit at least once every 12 months for established patients. However, CMS allows an exception to this requirement when both the provider and patient agree that the risks or burdens of an in-person visit outweigh the potential benefits. In those cases, the patient would be exempt from the annual in-person visit, but the rationale for this exemption must be clearly documented in the patient's medical record. It's important to note that this exception only applies to the annual in-person requirement. The initial in-person visit within six months of beginning telehealth services is still mandatory and cannot be bypassed using this documentation-based exception.

CMS has not issued detailed guidance on how to operationalize or reflect in claim forms this exception. Until further direction is released, best practice is to document the exception in the provider's note for the first telehealth session following October 1, 2025, and reference it again in subsequent visits if needed. Specifically, the documentation should include:

- A clear statement that both the provider and patient mutually agreed to defer the in-person visit
- The reason(s) why the in-person visit would pose greater risks or burdens to the patient
- A clinical justification, such as health status, mobility limitations, transportation access, or mental health factors

Unless CMS instructs otherwise, providers can assume that the standard billing format still applies—using POS 10 (when the patient is at home) with a code that is on the eligible Medicare telehealth list. However, because CMS has not formally clarified this, we strongly recommend confirming billing procedures with your Medicare Administrative Contractor (MAC) to ensure compliance.

How will CMS know if a telehealth service qualifies as "mental/behavioral health"? How should we indicate this when billing?

As of now, CMS has not issued explicit guidance on how it will determine whether a telehealth service qualifies as a mental or behavioral health service under the current policy. The most reasonable assumption is that CMS will rely on the CPT/HCPCS codes and service descriptions listed in the Medicare Telehealth Services List to make that distinction. Codes that are clearly and explicitly tied to mental or behavioral health (e.g., psychotherapy, psychiatric diagnostic evaluations) would most likely qualify.

However, there is no formal indicator or billing modifier at this time that providers can use to flag a telehealth claim as being for mental health purposes. This creates some ambiguity, particularly for services that may have dual purposes or be part of integrated care.

Until further guidance is issued by CMS—which we hope will come if the broader Medicare telehealth waivers are allowed to permanently expire—the best course of action is to ensure the code used clearly reflects a behavioral health service, as supported by documentation in the medical record. For additional clarity or payer-specific requirements, providers should contact their Medicare Administrative Contractor (MAC), who may offer more direct billing instructions.

Can a Physician Assistant (PA) or Nurse Practitioner (NP) meet the in-person requirement for Medicare mental health telehealth services, or does it need to be physician-to-physician?

Under federal Medicare regulations, a physician assistant (PA) or nurse practitioner (NP) may fulfill the in-person visit requirement if they are in the same specialty and subspecialty, and part of the same group as the telehealth provider. This flexibility is explicitly allowed under 42 CFR § 410.78(b)(3)(xiv)(C), which permits "another physician or practitioner" in the same group and specialty to perform the visit when the usual provider is unavailable. The term "practitioner" is defined in § 410.78(b)(2) to include:

- Physician assistants (§ 410.74)
- Nurse practitioners (§ 410.75)
- Clinical nurse specialists, psychologists, social workers, and several other types of providers. See regulatory language for full list.

Because PAs and NPs are included under that "practitioner" umbrella, CCHP believes they would be eligible. Just remember that the in-person visit must still be Medicare-billable so that it registers correctly with CMS and the exception applies only when the regular telehealth provider is unavailable.

Because CMS has not issued formal guidance that explicitly confirms this interpretation in writing, providers may want to check with their Medicare Administrative Contractor (MAC) to ensure alignment with their claims processing and audit expectations.

FQHCs & RHCs

Can FQHCs and RHCs continue to bill for telehealth (or telecommunications) services for non-behavioral health after September 30, 2025?

It's complicated. Under current federal law, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are *not* authorized to serve as distant site providers for non-behavioral/mental health services via "telehealth" as of October 1, 2025. However, based on CCHP's interpretation of the CY 2025 Physician Fee Schedule, CMS appears to have created a workaround: They will continue allowing FQHCs and RHCs to furnish non-behavioral services via telecommunications technology through December 31, 2025. It is critical to highlight, however, that CMS does not consider these to be "telehealth" services, but rather medical visits furnished through telecommunications. This important semantic distinction means they are not subject to the statutory restrictions that typically apply to distant site telehealth services.

This position is supported by:

- Transmittal 13133 and the Medicare Benefit Policy Manual, Chapter 13, page 47 which states that FQHCs and RHCs may continue billing for these visits using HCPCS code G2025, including those furnished via audio-only technology through December 31, 2025
- CMS Claims Processing Manual, Chapter 9 (updated June 2, 2025), which reiterates this policy
- CMS's Rural Health Clinic Booklet, pg. 12, (updated July 2025) and Federally Qualified Health Center Booklet, pg. 12 (updated April 2025)
- CY 2025 Physician Fee Schedule (released December 2025), which states: "*We are also finalizing, on a temporary basis, to allow payment for medical care non-behavioral health visits furnished via telecommunication technology in a manner that is similar to the payment mechanisms mandated by statute through December 31, 2024, RHCs and FQHCs will continue to bill for RHC and FQHC services furnished using telecommunication technology services by reporting HCPCS code G2025 on the claim through December 31, 2025.*"
- Proposed 2026 Physician Fee Schedule, (released in July 2025)) which reiterates the above and states: *"We propose to continue to calculate the payment amount for these services billed using HCPCS code G2025 based on the average amount for all Medicare telehealth services paid under the PFS, weighted by volume for those services reported under the PFS … we believe that continuing this payment methodology on a temporary basis through December 31, 2026 would provide flexibility to respond to any future statutory changes."*
- HHS Policy Updates webpage and Safety-Net Provider webpage which indicates FQHCs are able to bill for video technology services subject to the national average payment rates for comparable services under the physician fee schedule (PFS) through December 31, 2025.

Despite the sources above, there is still confusion around:

- Whether G2025 should still be used
- Whether the patient's home qualifies as an eligible location
- How to reconcile conflicting policy documents, such as the outdated April 2025 FAQ that indicates G2025 can only be billed *through* September 30, 2025

Some organizations are advising FQHCs to treat post-September 30 non-behavioral health live video and audio-only services as "telehealth," which would mean the FQHC/RHC is not eligible to bill, the home is *not* a valid originating site, and therefore G2025 would not be billable in Medicare. However, CCHP believes that later CMS transmittals, as well as manual updates and policy references in the proposed 2026 PFS (bulleted above) supersede the FAQs (as these are official published documents dated after the FAQ)on which these organizations are basing their reasoning, and that CMS' intent was to allow continued billing for these services using G2025.

***Bottom line*:** There is no official guidance from CMS yet that resolves these conflicts. We recommend:

- Reaching out to your Medicare Administrative Contractor (MAC) for billing advice
- Checking with NACHC or your state PCA in case they have received direct clarification from CMS
- Monitoring future CMS transmittals and guidance closely, especially if the telehealth waivers are not reinstated
- Sign up for the CCHP weekly newsletter, as we will keep you updated on any future developments in this area

If you've received definitive guidance or documentation on this issue, we'd be very interested in reviewing it—please email us at info@cchpca.org!

Can FQHCs and RHCs provide mental health services now that the waivers are expired, and are they subject to the in-person requirements?

Medicare allows Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to furnish mental health visits using real-time telecommunications technology, including both audio-video and audio-only modalities. This policy was established in the 2022 Physician Fee Schedule (PFS) final rule, which revised the definition of a "mental health visit" to include services delivered via interactive telecommunications when the patient is not physically present at the clinic. Note that audio-only technology may be used in cases where the patient either cannot access or does not consent to using video.

When billing for these services:

- Use Modifier 95 for synchronous audio-video visits.
- Use Modifier FQ or Modifier 93 for audio-only visits.
- RHCs must also append Modifier CG for mental health services.
- Use revenue code 0900 and an appropriate HCPCS code, such as G0470 for FQHCs.

Detailed CMS coding guidance is available via a Medicare Learning Network document (note that certain expiration dates are outdated in the document).

Under current fee-for-service CMS policy, an in-person visit is required within 6 months prior to initiating telehealth-based mental health services, followed by an annual in-person visit thereafter (with certain

exceptions). However, CMS has waived this requirement for FQHCs and RHCs through December 31, 2025, as noted in the CY 2025 Physician Fee Schedule. However, the Proposed 2026 Physician Fee Schedule indicates that CMS may align this FQHC/RHC policy with FFS Medicare, where the in-person mental health requirements are already in place as of October 1, 2025. If that alignment occurs, FQHCs and RHCs may be subject to the same in-person requirements.

Providers should stay alert for further CMS guidance on this issue, particularly when the 2026 Final Rule is released.

APPLICABILITY TO OTHER PAYERS (MEDICAID, PRIVATE PAYERS & MEDICARE ADVANTAGE)

Will the end of the Medicare telehealth flexibilities affect Medicaid or other private payers?

Not necessarily. The recent changes to Medicare telehealth policy—including the expiration of certain flexibilities on September 30, 2025—apply specifically to traditional Medicare (Fee-for-Service). They do not automatically apply to Medicaid or commercial/private plans, including Medicare Advantage.

For Medicaid, each state determines its own telehealth policies and coverage rules. While some Medicaid programs choose to follow Medicare's lead, they are not required to. Changes in Medicare may influence state decision-making down the road, but they do not trigger any automatic changes to Medicaid benefits. Please reference the Medicaid Category of CCHP's Telehealth Policy Finder for each state's telehealth policy.

Similarly, private payers often model their telehealth coverage after Medicare, but again, they are not obligated to. Coverage decisions are based on individual plan policies and contracts, and some states may also have laws in place that require coverage of telehealth services, and would prohibit the type of restrictions Medicare currently has in place. You can reference CCHP's Private Payer Category in our Telehealth Policy Finder for information on state private payer laws.

Medicare Advantage plans must cover telehealth at least to the extent that Original Medicare does, but they may offer additional flexibilities. However, many Medicare Advantage plans do choose to mirror Original Medicare policy, since that is the baseline of which they are obligated to meet. If that's the case, the expiration of the waivers could also impact which telehealth services are covered under the Medicare Advantage plan.

If you're unsure whether a specific service is covered via telehealth under a Medicaid program or private payer, it's best to check the latest provider bulletins or reach out to the payer directly for confirmation.

If you, or someone you know, have additional questions pertaining to these areas of telehealth policy – or any other area of telehealth policy, for that matter – please email us at info@cchpca.org and one of our experts will reply as soon as possible! It makes our day to be able to help the many other telehealth policy enthusiasts out there!

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