



Medicare Waiver Expiration & Telehealth FAQs

(updated 10/15/25)

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. Please note that this FAQ has been updated since its original release, to now reflect updated information provided by CMS on October 15, 2025.

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?

As a general rule, payment for behavioral health services furnished via telehealth to patients in their homes is only allowed if the physician or practitioner has conducted an in-person, non-telehealth visit within the 6 months prior to the *initial* mental health telehealth service. After that first telehealth service, patients must have an in-person visit at least once every 12 months. Limited exceptions may apply if both patient and provider determine the subsequent in-person visit would create undue burden, and the decision is documented.

CMS did clarify in an [October 2025 FAQ](#) that the 6-month prior in-person requirement does *not* apply to beneficiaries who began receiving mental health telehealth services in their homes on or before September 30, 2025. These patients are considered established and must simply comply with the ongoing 12-month in-person visit requirement. CMS is aligning policy for behavioral health services furnished remotely by hospital staff to patients in their homes with the above rules as well.

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?

When the Medicare telehealth waivers expired on September 30, 2025, many organizations interpreted again applicable federal laws to mean that FQHCs and RHCs could no longer serve as distant site providers for non-behavioral health services via telehealth. Additionally, a prior FAQ released earlier in 2025 by CMS created confusion in that regard by suggesting that billing under HCPCS code G2025 would no longer be permitted after that date. However, subsequent [CMS transmittals](#), [manual updates](#), and language in the [CY 2025 Physician Fee Schedule](#) and [Proposed 2026 Physician Fee Schedule](#) indicated that FQHCs and RHCs could continue billing for these visits through December 31, 2025. Importantly, CMS described these as visits furnished via telecommunications technology rather than “telehealth” services, a distinction that allowed them to avoid statutory telehealth restrictions. Nevertheless, this inconsistency created uncertainty for providers.

In its updated [October 2025 FAQ](#), CMS has now aligned its information with what had been previously published in their transmittals, manual updates, and 2025 PFS, confirming that 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. Payment for the code is based on the average amount for all Medicare telehealth services paid under the PFS, weighted by volume for those services reported under the PFS. Note that CMS also included in the [proposed 2026 PFS](#) an extension of this policy to allow non-behavioral health services furnished via telecommunications technology to be billed through December 31, 2026. If finalized as currently written, that proposal would

provide additional protection for FQHCs and RHCs to continue billing in the absence of renewed legislative waivers.

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 FQHC/RHC 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 clarified in an [October 2025 FAQ](#) document that for behavioral health services furnished by RHCs and FQHCs where the patient is present virtually, the in-person visit requirement is delayed until at least January 1, 2026. That means FQHCs and RHCs can continue providing behavioral health services via telehealth without the 6-month prior or 12-month ongoing in-person requirements applying during this transition period. CMS will likely address this in the Final 2026 Physician Fee Schedule (due to be released in November).

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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