TELEHEALTH MEDICARE POLICIES POST-SEPTEMBER 30, 2025 (Updated 11/7/25)

The following outlines the current active telehealth policies as the Center for Connected Health Policy (CCHP) understands them. These are policies that are in place due to the expiration of the federal Medicare telehealth waivers that have existed since the 2020 pandemic began. Sources that led CCHP to our interpretation are provided. However, CCHP wishes to state that this resource document is for informational and educational purposes only and are not to be considered legal advice nor a guarantee on reimbursement. Due to some information that has been released, there could be other interpretations regarding the policies. If another source that is more recent than the ones cited here contradicts our interpretations, please feel free to forward them to CCHP for review. **Please note, rows that are orange contain updated information as of November 7, 2025.**

PATIENT LOCATION

CURRENT POLICY *(post 9/30/25)*	EXCEPTIONS/REQUIREMENTS	SOURCE/HISTORY	NOTES
Patient location (originating site) must be in an eligible geographic location (rural location)	Geographic requirement does not apply when treating: • Stroke • End Stage Renal Disease (ESRD) • Substance Use Disorder (SUD) • Provision of mental and behavioral health services if certain requirements are met*	42 USC § 1395(m)(m)(4)(c)	See further elaboration on the mental and behavioral health exceptions in the mental health section below.*
Patient must be in a specific type of site during the time of the telehealth visit: • Physician/Practitioner Office • Critical Access Hospital (CAH) • Rural Health Clinic (RHC) • Federally Qualified Health Center (FQHC) • Hospital	Site requirement does not apply when treating: • Stroke • End Stage Renal Disease (ESRD) • Substance Use Disorder (SUD) • Provision of mental and behavioral health services if certain requirements are met*	42 USC § 1395(m)(m)(4)(c)	See further elaboration on the mental and behavioral health exceptions in the mental health section below.*

• Hospital-based or CAH-based renal dialysis center • Skilled Nursing Facility • Community Mental Health Center • Renal Dialysis Facility • A Rural Emergency Hospital • A Mobile Stroke Unit (for acute stroke care) • Patient home (in certain cases)			

Asterisk **above denotes a reference to mental health services, which have distinct requirements/exceptions and are described further in the Mental Health section below.*

ELIGIBLE PROVIDERS

CURRENT POLICY *(post 9/30/25)*	EXCEPTIONS/REQUIREMENTS	SOURCE/HISTORY	NOTES
Eligible providers are defined as "physician" (42 USC § 1395x(r)) OR "practitioner" (42 USC § 1395u(b)(18)(C)). Notably, this excludes physical therapists, occupational therapists and speech language pathologists and audiologists.	N/A	42 USC § 1395(m)(m)(4)(d) & (e)	Full list of eligible providers: • Physicians • Nurse practitioners (NPs) • Physician assistants (PAs) • Nurse-midwives • Clinical nurse specialists (CNSs) • Certified registered nurse anesthetists • Clinical psychologists (CPs) and clinical social workers (CSWs) • Registered dietitians or nutrition professionals • Marriage and Family Therapists and Counselors

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) & RURAL HEALTH CLINICS (RHC)*

CURRENT POLICY *(post 9/30/25)*	EXCEPTIONS/REQUIREMENTS	SOURCE/HISTORY	NOTES
FQHCs and RHCs are not eligible to act as distant site providers who use telehealth to deliver services to Medicare enrollees.	• FQHCs and RHCS may use **telecommunications technologies** (video and audio-only) to provide non-behavioral health/mental health services (or medical services) to Medicare enrollees through December 31, 2026. • *See below for behavioral health exceptions/requirements.	Source to show FQHCs/RHCs are not on the eligible provider list: 42 USC § 1395(m)(m)(4)(d) & (e) Sources to show FQHCs & RHCs may use telecommunications technologies to provide non-behavioral health/mental health services (or medical services) to Medicare enrollees until December 31, 2026: Final Rule 2026 Physician Fee Schedule. Final 2025 Physician Fee Schedule. CMS Manual System, Pub 100-02 Medicare Benefit Policy, Transmittal 13133 (March 20, 2025). P. 25, Medicare Claims Processing Manual, Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers (Issued June 9, 2025), p. 36 & CMS Telehealth FAQ (updated 10/15/25)	As of October 15, 2025, CMS has aligned their Telehealth FAQ with the policies stated in their Claims Processing Manual and Medicare Benefit Policy Transmittal, as well as the 2025 PFS. The Oct. 15 updated FAQ notes that: *"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."*** The final rule for the 2026 Physician Fee Schedule extended this expiration date an additional year to **December 31, 2026.**

Asterisk **above denotes a reference to mental health services, which have distinct requirements/exceptions and are described further in the Mental Health section below.*

MENTAL/BEHAVIORAL HEALTH

CURRENT POLICY	EXCEPTIONS/REQUIREMENTS	SOURCE/HISTORY	NOTES
Medicare will cover mental health services that take place in the home and without having to meet the geographic requirements if the patient is being treated for SUD or a co-occurring mental health condition.	Patient must be treated for SUD or a co-occurring mental health condition.	42 USC § 1395(m)(m)(7); All Fee-For-Service Providers Spotlight – Update on Processing of Telehealth and Acute Hospital Care at Home Claims (11/6/2025)	From 11/6/25 CMS Claims Update: Medicare is processing claims for telehealth mental health service for patients with a diagnosis code within the F01.A0-F99 range that are not provided by a physical therapist, occupational therapist, speech language pathologist or audiologist. All other claims are being returned and should be resubmitted, if they meet the statutory requirements. All Fee-For-Service Providers Spotlight – Update on Processing of Telehealth and Acute Hospital Care at Home Claims (11/6/2025)
Medicare will cover mental health services that take place in the home and without having to meet the geographic requirements if certain conditions are met.	The telehealth provider furnishes an item or service in-person within 6 months prior to the first-time telehealth is being used to treat the Medicare enrollee. Every 12 months after the start of the telehealth services, the provider must have a follow-up in-person visit with the patient. Certain exceptions apply.	42 USC § 1395(m)(m)(7)(b); All Fee-For-Service Providers Spotlight – Update on Processing of Telehealth and Acute Hospital Care at Home Claims (11/6/2025)	Medicare is processing claims for telehealth mental health service for patients with a diagnosis code within the F01.A0-F99 range that are not provided by a physical therapist, occupational therapist, speech language pathologist or audiologist. All other claims are being returned and should be resubmitted, if they meet the statutory requirements. All Fee-For-Service Providers Spotlight – Update on Processing of Telehealth and Acute Hospital Care at Home Claims (11/6/2025)
Prior in-person requirement applicable to above policy: Mental health relationships formed via		CMS Telehealth FAQ (10/15/25 version)	The Oct 15 updated CMS FAQ notes:

telehealth prior to October 1, 2025 are considered established, therefore a prior in-person service delivered by the telehealth provider to the patient does not need to take place.			*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.*
Prior in-person requirement applicable to above policy: If the regular provider isn't available, a colleague in the same specialty within the same group practice can do the in-person visit.		CFR § 410.78(b)(3)(xiv)(C)	
Subsequent in-person requirement applicable to above policy: Every 12 months after the start of the telehealth services, the provider must have a follow-up in-person visit with the patient. Certain exceptions apply.	If the provider and patient determine that undue hardship would occur in trying to meet the in-person requirement in the 12-month period, they may forego it if documented in the patient record.	CFR § 410.78(b)(3)(xiv)(B)	As noted above, it is not clear when the countdown to the 12-month requirement starts (October 1, 2025, or earlier, depending on when the relationship was established).
FQHC/RHC Mental Health Allowances: FQHCs & RHCs may use telecommunications technology to provide mental/behavioral health services.	Permanent policy requires a prior and subsequent in-person visit for FQHC/RHC mental health allowances.	CFR § 405.2463(b)(3) (includes requirement for the prior and subsequent in-person visit) Final 2026 Physician Fee Schedule; Final 2025 Physician Fee Schedule; CMS Telehealth FAQ (10/15/25 version).	*"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.* CMS Telehealth FAQ (10/15/25 version) In the final rule for the 2026 Physician Fee Schedule, CMS aligned its prior in-person policy for FQHCs and RHCs using telecommunications technology to provide a mental health visit with what Congress

			adopted for mental health visits provided via telehealth in the Medicare program. Therefore, starting October 1, 2025, if an FQHC or RHC began to use telecommunications technology for a mental health visit with a patient, there must have been a prior in-person visit within 6 months of the initial telehealth visit with that patient. Additionally, every 12 months after the patient had been receiving services via telecommunications technology, there must be a follow-up in-person visit with the patient unless the provider and patient deem meeting that requirement and delaying receipt of services would be detrimental to the care of the patient. However, CMS clarified that application of the in-person requirements only applies to services post-September 30, 2025. Therefore, similar to the above exceptions for overall mental health services, if a patient had been receiving services for mental via telecommunications technology from September 30, 2025 and earlier, they should be deemed to have an established relationship and would not need to meet the prior in-person visit requirement, but would need to meet the 12-month follow-up requirement.

			2026 Final Rule Physician Fee Schedule

AUDIO-ONLY

CURRENT POLICY	EXCEPTIONS/REQUIREMENTS	SOURCE/HISTORY	NOTES
CMS will pay for services furnished via telecommunications system by an eligible provider.		42 USC § 1395(m)(1)	
An "interactive telecommunications system" is defined as: *Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Interactive telecommunications system may also include two-way, real-time audio-only communication technology for any telehealth service furnished to a patient in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined in the previous sentence, but the patient is not capable of, or does not consent to, the use of video technology.*	For audio-only to be eligible for coverage, 2 conditions must be met: • Furnished to the patient in their home **AND** • Provider is technically capable of using live video but the patient is not capable or does not want to use live video.	CFR § 410.78(a)(3)	As noted earlier, only certain services are eligible to take place in the home: • ESRD • SUD • SUD & Co-occurring mental health condition • Mental Health services if certain requirements are met. Therefore, only the foregoing services can be provided via audio-only because one of the conditions for audio-only that must be met is that the patient is at home. CMS Telehealth FAQ (10/15/25 version) states: 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.

MEDICARE HOSPITAL AT HOME PROGRAM

CURRENT POLICY	EXCEPTIONS/REQUIREMENTS	SOURCE/HISTORY	NOTES
Medicare Hospital at Home program expired on September 30, 2025.		HR 1968; Acute Hospital Care at Home (AHCAH) CMS Notice; CMS Special Edition Update on Processing of Telehealth and Acute Hospital Care at Home Claims (Nov. 6, 2025).	The program had an expiration date of September 30, 2025. The Centers for Medicare and Medicaid Services (CMS) issued a notice regarding the Acute Hospital Care at Home (AHCAH) initiative, advising all hospitals with active AHCAH waivers to discharge, or return to the hospital, all inpatients on September 30, 2025, due to the lack of Congressional action to extend the program under the telehealth waivers. CMS stopped accepting AHCAH requests for participation on September 1, 2025.

			From 11/6/25 CMS Claims Update: *If hospitals submit AHCAH claims with dates of service of October 1, 2025, or later, they will be returned to the provider for correction. Should hospitals perform AHCAH services beyond those for which Medicare can currently pay, in anticipation of possible Congressional action, hospitals may choose to continue to hold claims and may want to evaluate providing beneficiaries with an Advance Beneficiary Notice of Noncoverage (ABN).* *Should hospitals not want to hold these claims, hospitals may submit (or resubmit, if applicable) these claims for denial. The submission of non-covered days or a completely non-covered claim with bill type 110 and condition code 21 informs Medicare that the hospital provided AHCAH services on days that are currently statutorily excluded from payment, and the claim will be denied, affording the beneficiary and hospital with the rights of a denied service. Should Congress act in the future and retroactively extend the waivers, CMS will provide future guidance on whether hospitals will need to resubmit AHCAH claims previously submitted for non-covered days or denial.*