



Physician Services Version

KEY CONCEPTS OUTLINE

Module 13: Telehealth and Virtual Services

- I. Telehealth vs. Communications Based Technology Services
 - A. Telehealth Services are a Medicare benefit payable under Medicare Part B (Supplementary Medical Insurance).
 1. Background:
 - a. Medicare's coverage for telehealth for home- and community-based care was first introduced in the 1997 Budget Balanced Act and then implemented in the 2001 Medicare Physician Fee Schedule.
 - (i) Originally limited in scope, the types of services payable as a telehealth benefit, have incrementally expanded since inception.
 2. Approved telehealth services can be found on the CMS website at the following:
 - a. <https://www.cms.gov/medicare/coverage/telehealth/list-services>
 - b. Telehealth services are generally added on an annual basis.
 - c. Changes to the list of Medicare telehealth services are made using the annual physician fee schedule proposed rule published in the summer and the final rule published by November 1st each year.
 3. Two Categories of Coverage
 - a. Permanent - meaning the services will remain on the telehealth listing
 4. Provisional – meaning the services will have refinements to telehealth policies based on certain provisions.

4. Delivery of Telehealth Services

- (i) Telehealth services must be provided via an interactive audio and video telecommunications system that allows for real-time communication between the provider and the beneficiary.
 - (a) Exception: Asynchronous technology, the transmission of medical information to the distant site and reviewed later by the physician or practitioner, is permitted in federal telemedicine demonstration programs.
 - (1) Applicable states are Alaska and Hawaii.

5. Originating Site

- a. The Full-Year Continuing Appropriations and Extensions Act, 2025, will continue to allow beneficiaries to receive telehealth services wherever they are in the United States and its territories through September 30, 2025.
 - (i) Not limited to rural areas, or medical facilities <See: *Telehealth FAQ Calendar Year 2025*>
- b. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii. <Medicare Claims Processing Manual, Pub 100-04, Chapter 12 §190.2.3>

6. Distant Site

- a. The location of the provider delivering the service.
- b. Eligible distant site providers:
 - (i) Physicians
 - (ii) Nurse practitioners
 - (iii) Physician assistants
 - (iv) Nurse-midwives
 - (v) Clinical nurse specialists
 - (vi) Certified registered nurse anesthetists

(vii) Clinical psychologists and clinical social workers (may not bill for psychiatric diagnostic interviews or E/M services)

(viii) Registered dietitians (RD)

(ix) Nutrition professionals

(x) Audiologists

(xi) Occupational therapists

(xii) Physical therapists

(xiii) Mental health counselors (MHC)

(xiv) Marriage and family therapists

c. Note: Through September 30, 2025, all providers eligible to bill Medicare for professional services can provide distant site telehealth. <See *MLN Booklet, Telehealth Services*, p 4>

7. Frequency Limitations for Specific Services Suspended through CY 2025

- a. Subsequent inpatient and subsequent nursing facility visits (CPT Codes: 99231, 99232, 99233, 99307, 99308, 99309, and 99310); and
- b. Critical care consultation (CPT Codes: G0508 and G0509). <See *MLN Booklet, Telehealth Services*, p 5>

8. Telehealth Billing and Coding

a. Distant Site Billing

(i) Submit the appropriate HCPCS or CPT code identifying the telehealth service.

(ii) Place of Service, Effective January 1, 2024

(a) To indicate the service was provided as a professional telehealth service from a distant site, an appropriate place of service code (POS) must be reported.

(1) POS 02: Telehealth Provided Other than in Patient's Home

- a. Descriptor: The location where health services and health related services are provided or received, through telecommunication technology. Patients are not located in their home when receiving health services or health related services through telecommunication technology.

(2) POS 10 – Telehealth Provided in a Patient’s Home

- a. Descriptor: The location where health services and health related services are provided or received through telecommunication technology. Patient is in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology
- b. POS 10 and modifier -95 are to be used through December 31, 2024, when:
- c. The clinician is in the hospital and the patient in their home, or
- d. Outpatient therapy provided by telehealth by PT, OT, or SLPs

- (3) Payment for the above place of service is at the non-facility physician fee schedule rate.

(iii) Modifiers

(a) Professional Billing

(b) 95 - Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System

- (1) Opioid Treatment Programs will use for counseling and therapy provided using audio-video only technology.

(c) 93- Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system"

- (1) Used by Opioid Treatment Programs (OTP), RHCs, and FQHCs

- a. For OTP, modifier -93 should only be used for counseling and therapy using audio-only technology.

(d) GQ – Service delivered via asynchronous telecommunications.

- (1) Note: Asynchronous “store and forward” technology is permitted only in Federal telemedicine demonstration programs in Alaska or Hawaii.

b. Originating Site

- (i) HCPCS code Q3014 describes the Medicare telehealth originating site facility fee.

- (a) Separately billable

- (b) CY 2025 Payment - \$31.04

c. Supervision

- (i) Medicare extended the definition of direct supervision that allows the supervising physician or practitioner to provide supervision through a virtual presence using real-time audio-visual interactive telecommunications through December 31, 2025.

- (a) Teaching physician supervision

- (1) Virtual presence when billing for services provided involving residents in all teaching settings but only in clinical situations when they provide the service virtually through December 31,

- i. Examples: A 3-way telehealth visit with the patient, resident, and teaching physician in separate locations

9. Mobile Stroke

- (i) There are no geographic limitations for the originating site of telehealth services furnished on or after January 1, 2019, for the purpose of diagnosis, evaluation, or treatment of symptoms of acute stroke <2018 Bipartisan Budget Act, see *MLN Matters 10883*>

(a) Modifier G0 is appended to the HCPCS/CPT code when reported for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

(b) Valid for the following:

(1) Telehealth distant site codes billed with Place of Service (POS) code 02 or Critical Access Hospitals, CAH method II (revenue codes 096X, 097X, or 098X); or

(2) Telehealth originating site facility fee, billed with HCPCS code Q3014.

10. New Telehealth Codes for CY 2025

a. Caregiver Training Services -provisional basis

(i) CPT codes 97550, 97551, 97552, 96202, and 96203

(ii) HCPCS codes G0539 and G0543 -

b. Pre-exposure prophylaxis (PrEP counseling) – permanent basis

(i) HCPCS codes G0011 and G0013

c. Safety planning interventions -permanent basis

(i) HCPCS code F0560

II. Communications Based Technology Services

A. Services that are furnished via telecommunications technology; but are not considered Medicare telehealth services. Therefore, it would not be appropriate to report POS 02 or telehealth modifiers.

1. These services are distinct from telehealth.

2. Types of services that are not ordinarily furnished in person <2019 MPFS Final Rule>

3. Can be asynchronous

B. Virtual Check-Ins – HCPCS Codes G2010-G2012 and G2250-G2251

1. To be used by providers who can bill evaluation and management services:
 - a. G2010 - Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment.
 - b. G2012 - Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
2. For use by nonphysician qualified health care professionals who cannot bill evaluation and management (E/M) codes:
 - a. G2250 - Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.
 - b. G2251 - Brief communication technology-based service, e.g., virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion.

(a) .

3. Correct Reporting

- a. The services must be initiated by the patient,

- (i) Unrelated to a previous evaluation or treatment session provided within the last seven days,
- (ii) Conducted through a HIPAA-compliant platform, and
- (iii) Medically necessary (requires clinical decision making and is not for administrative or scheduling purposes).

4. E -Visits – Online Assessments

- a. E-visits or online assessment and management services are covered in all areas (not just rural), including the patient's home.
- b. CMS clarified that certain clinicians who may not independently bill for E/M visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists, clinical social workers) can also provide these e-visits as professional services only.
- c. CMS expects e-visit services to be initiated by the patient; however, practitioners can educate patients on the availability of the service.
- d. No limitation to location of the practitioner/clinician to location of the patient
- e. CPT codes for Practitioners
 - (i) 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
 - (ii) 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11–20 minutes
 - (iii) 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
- f. CPT Codes for Other Clinicians

Examples of qualified nonphysician health care professionals include registered dietitian, physical therapist, occupational therapist, and speech-language pathologist.

- (i) 98970 - Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- (ii) 98971 - Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- (iii) 98972 - Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
- (iv) Correct Reporting:
 - (a) Initiated by the patient,
 - (b) unrelated to a previous evaluation or treatment session provided within the last seven days,
 - (c) conducted through a HIPAA-compliant platform, and
 - (d) medically necessary (requires clinical decision making and is not for administrative or scheduling purposes).
 - (e) The established patient and HIPAA requirements may be waived by some payers during the public health emergency.
 - (f) Documentation of clinical decision-making and storage of the exchange are required.

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with comment period (76 FR 73096 through 73097), physicians and NPPs who may independently bill Medicare for their services and who are counseling individuals would generally report office or other outpatient E/M CPT codes for office visits that involve significant counseling, including genetic counseling, and these office visit CPT codes are already on the Medicare telehealth services list. CPT code 96040 would only be reported by genetic counselors for genetic counseling services. Genetic counselors are not among the practitioners who can bill Medicare directly for their professional services, and they are also not practitioners who can furnish telehealth services as specified in section 1834(m)(4)(E) of the Act. As such, we noted that we do not believe that it would be necessary or appropriate to add CPT code 96040 to the Medicare telehealth services list.

HCPSC code S0265 is a Medication, Supplies, and Services code. There is no separate payment under the PFS for this category of codes. Therefore, we did not propose to add this service to the Medicare telehealth services list.

We received public comments on the requests to add services to the Medicare telehealth services list for CY 2021. The following is a summary of the comments we received and our responses.

Comment: Commenters broadly supported our proposal to add HCPCS codes and CPT codes 90853, 96121, G2212, 99483, 99334, 99335, 99347, and 99348 to the Medicare telehealth list on a Category 1 basis.

Response: We thank the commenters for their support and feedback.

Comment: One commenter opposed the addition of G2211 to the Medicare telehealth list on the basis they do not agree the creation of the code.

Response: We thank the commenter for their feedback and refer them to section II.F.2.c. of this final rule for further discussion of payment policies for HCPCS code G2211. We note that HCPCS codes G2211 and G2212 replace GPC1X and 99XXX respectively, please see section II.F.2.c in this final rule.

Comment: One commenter requested clarification on the addition of CPT codes 99347 and 99348 (*Home visit for the evaluation and management of an established patient*). Specifically, the commenter requested clarification from CMS on the situations in which a home visit after the end of the PHE for COVID-19 would be allowed via telehealth.

Response: While the patient's home cannot serve as an originating site (where the patient is located) for purposes of most Medicare telehealth

services, the SUPPORT for Patients and Communities Act amended section 1834(m)(4)(C) of the Act and added a new paragraph at section 1834(m)(7) of the Act to remove geographic limitations and authorize the patient's home to serve as a telehealth originating site for purposes of treatment of a SUD or a co-occurring mental health disorder, furnished on or after July 1, 2019, to an individual with a SUD diagnosis. These domiciliary/home visits contain the same elements and similar descriptors to the O/O E/M visits, and therefore, we believe there is sufficient justification to add them to the Medicare telehealth services list on a Category 1 basis. We are adding these to the telehealth services list because an office/outpatient visit might not always most accurately or specifically describe the type of visit furnished to treat an individual in their home for an SUD or co-occurring mental health disorder; and that sometimes one of the domiciliary/home visit codes would more accurately describe the service.

Comment: One commenter stated that Assessment and Care Planning for Patients with Cognitive Impairment (CPT Code 99483) should not be added at this time until more study can be done to assess the appropriateness of this service being delivered in the telehealth context given that many cognitive impairments and symptoms may require in-person assessment.

Response: We continue to believe that CPT code 99483 is sufficiently similar to an office visit to warrant addition to the Medicare telehealth list on a permanent basis in that it involves evaluating and managing a patient's cognitive impairment in an office/outpatient setting. When the AMA CPT Editorial Panel created this code, they assumed that the work associated with assessment and care planning for patients with cognitive impairment had been reported with CPT code 99215 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family*), which is currently on the Medicare telehealth list.

After considering the public comments received, we are finalizing our proposal and adding HCPCS codes G2211 and CPT codes 90853, 96121, G2212, 99483, 99334, 99335, 99347, and 99348 to the Medicare telehealth list for CY 2021.

Comment: Commenters expressed opposition to CMS' decision not to propose to add Medical Genetics services (CPT code 96040) to the Medicare telehealth services list.

Response: We note that CPT code 96040 is not separately billable under the PFS; it is considered bundled into O/O E/M visits, which are already on the Medicare telehealth services list. Therefore, we believe it is unnecessary, and could potentially be confusing, to add CPT code 96040 to the list. Only codes that are separately billable can be added to the Medicare telehealth list. As we stated in the CY 2012 PFS final rule with comment period (76 FR 73096 through 73097), physicians and NPPs who furnish and bill Medicare for these services would generally report office or other outpatient E/M CPT codes for office visits that involve significant counseling, including genetic counseling; and the office visit CPT codes are already on the Medicare telehealth services list. CPT code 96040 would only be reported by genetic counselors for genetic counseling services. Genetic counselors are not among the practitioners who can bill Medicare directly for their professional services, and they are also not practitioners who can furnish telehealth services as specified in section 1834(m)(4)(E) of the Act. As such, we do not believe that it would be necessary or appropriate to add CPT code 96040 to the Medicare telehealth services list.

c. Proposed Temporary Addition of a Category 3 Basis for Adding to or Deleting Services From the Medicare Telehealth Services List

Legislation enacted to address the PHE for COVID-19 provided the Secretary with new authorities under section 1135(b)(8) of the Act, as added by section 102 of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. 116–123, March 6, 2020) and subsequently amended by section 6010 of the Families First Coronavirus Response Act (Pub. L. 116–127, March 18, 2020) and section 3703 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116–136, March 27, 2020)), to waive or modify Medicare telehealth payment requirements during the PHE for COVID-19. We established several flexibilities to accommodate these

changes in the delivery of care. Through waiver authority under section 1135(b)(8) of the Act, in response to the PHE for COVID-19, we removed the geographic and site of service originating site restrictions in section 1834(m)(4)(C) of the Act, as well as the restrictions in section 1834(m)(4)(E) of the Act on the types of practitioners who may furnish telehealth services, for the duration of the PHE for COVID-19.¹ We also used waiver authority to allow certain telehealth services to be furnished via audio-only communication technology. In the March 31st COVID-19 IFC, we added 89 services to the Medicare telehealth services list on an interim basis. Through the “Medicare and Medicaid Programs; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency” interim final rule with comment period (IFC), (which was issued on May 1, 2020, and was effective upon publication in the May 8, 2020 **Federal Register** (85 FR 27550 through 27649)) (hereinafter referred to as the “May 8th COVID-19 IFC”), on an interim basis for the duration of the PHE for COVID-19, we removed the requirement in our regulations that we undertake rulemaking to add or delete services on the Medicare telehealth services list so that we could consider the addition of services on a subregulatory basis as they were recommended by the public or identified internally. On a subregulatory basis, we simultaneously added 46 more services to the Medicare telehealth services list on an interim basis when we issued the May 8th COVID-19 IFC. Finally, on October 14, 2020 we added 11 more services to the Medicare telehealth list on a subregulatory basis. For a full list of Medicare telehealth services please see the CMS website: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.

At the conclusion of the PHE for COVID-19, these waivers and interim policies will expire, payment for Medicare telehealth services will once again be limited by the requirements of section 1834(m) of the Act, and we will return to the policies established through the regular notice and comment rulemaking process, including the previously established Medicare telehealth services list, as modified by subsequent changes in policies and additions to the telehealth services list adopted through rulemaking, including in this final rule. We believe that the experiences of clinicians who are

furnishing telehealth services during the PHE for COVID-19 will be useful to inform decisions about which of the services we added temporarily to the Medicare telehealth services list might be appropriate to add on a permanent basis. However, we also recognize that the annual PFS rulemaking schedule may not align perfectly with the expiration of the PHE for COVID-19, and that the clinicians providing services via telehealth during the PHE may not have the opportunity to conduct the kinds of review or develop the kind of evidence we usually consider when adding services to the Medicare telehealth services list on a permanent basis. In the event that the PHE for COVID-19 ends prior to the end of CY 2021, stakeholders might not have the opportunity to use our current consideration process for telehealth services to request permanent additions to the Medicare telehealth services list prior to those services being removed from the Medicare telehealth services list. This is especially true for those services that might need to be considered on a Category 2 basis, which involves providing supporting documentation to illustrate the clinical benefit of such services. Recognizing the extent to which practice patterns are shifting as a result of the PHE for COVID-19 from a model of care based on in-person services to one that relies on a combination of in-person services and virtual care, we noted that we believe that it would be disruptive to both clinical practice and beneficiary access to abruptly eliminate Medicare payment for these services when furnished via telehealth as soon as the PHE for COVID-19 ends without first providing an opportunity to use information developed during the PHE to support requests for permanent changes to the Medicare telehealth services list.

As previously noted, in response to the PHE for COVID-19, we added a broad range of services to the Medicare telehealth services list. Before eliminating the full range of these services from the Medicare telehealth services list and potentially jeopardizing beneficiary access to those services that have been clinically beneficial, based primarily on the timing of annual rulemaking, we noted that we believe it would be prudent to collect information from the public regarding which, where, and how various telehealth services have been in use in various communities during the COVID-19 response. Feedback from patients and clinicians is essential to helping CMS understand how the use of telehealth

services may have contributed positively to, or negatively affected, the quality of care provided to beneficiaries during the PHE for COVID-19, enabling us to better determine which services should be retained on the Medicare telehealth services list until we can give them full consideration under our established rulemaking process.

Therefore, we proposed to create a third category of criteria for adding services to the Medicare telehealth services list on a temporary basis. This new category would describe services that would be included on the Medicare telehealth services list on a temporary basis. We would include in this category the services that were added during the PHE for COVID-19 for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. Recognizing that the services we would add on a temporary basis under Category 3 would ultimately need to meet the criteria under categories 1 or 2 in order to be permanently added to the Medicare telehealth services list, and the potential for evidence development that could continue through the Category 3 temporary addition period, we considered each of the services we added on an interim final basis during the PHE for COVID-19.

In developing the proposal to add specific services on a Category 3 basis, we conducted a clinical assessment to identify those services for which we could foresee a reasonable potential likelihood of clinical benefit when furnished via telehealth outside the circumstances of the PHE for COVID-19 and that we anticipate would be able to demonstrate that clinical benefit in such a way as to meet our Category 2 criteria in full. Any service added under the proposed Category 3 would remain on the Medicare telehealth services list through the calendar year in which the PHE for COVID-19 ends. When assessing whether there was a potential likelihood of clinical benefit for a service such that it should be added to the Medicare telehealth services list on a Category 3 basis, we considered the following factors:

- Whether, outside of the circumstances of the PHE for COVID-19, there are increased concerns for patient safety if the service is furnished as a telehealth service.
- Whether, outside of the circumstances of the PHE for COVID-19, there are concerns about whether the provision of the service via telehealth is likely to jeopardize quality of care.

¹ <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.

- Whether all elements of the service could fully and effectively be performed by a remotely located clinician using two-way, audio/video telecommunications technology.

We recognized that the circumstances of the PHE for COVID-19 have provided clinicians with the opportunity to use telecommunications technology in health care delivery in a scope and manner far surpassing the telehealth services described under section 1834(m) of the Act, particularly as a result of the removal of geographic and site of service restrictions, and the addition of many services to the Medicare telehealth services list. When adding services to the Medicare telehealth services list on an interim basis during the PHE for COVID-19, we reassessed services on a Category 2 basis in the context of the widespread presence of COVID-19 in the community. We recognized that healthcare access issues could arise due to the immediate potential exposure risks to patients and healthcare workers, and that the use of telecommunication technology could mitigate risk and facilitate clinically appropriate treatment. In the context of the PHE for COVID-19, we found that all of the added services met the Category 2 criteria on the basis that there is a patient population who would otherwise not have access to clinically appropriate care (85 FR 19234). While the interim addition of a broad swath of services to the Medicare telehealth services list is responsive to critical needs during the PHE for COVID-19, the impact of adding these services to the Medicare telehealth services list on a permanent basis is currently unknown. Specifically, although it is possible to assess the uptake among health care practitioners of the added telehealth services, the extent to which service delivery via telehealth demonstrates clinical benefit outside the conditions of the PHE for COVID-19 is not known. Adding services to the Medicare telehealth services list on a Category 3 basis will give the public the opportunity to gather data and generate requests to add certain services to the Medicare telehealth services list permanently, which would be adjudicated on a Category 1 or Category 2 basis during future PFS annual rulemaking, while maintaining access to telehealth services with potential likelihood of clinical benefit. We proposed that the Category 3 criteria and the basis for considering additions to the Medicare telehealth services list would be temporary, to expire at the

end of the calendar year in which the PHE for COVID-19 expires.

We identified a number of services that we believe, based on our clinical assessment, fit the Category 3 criteria enumerated above in that we did not identify significant concerns over patient safety, quality of care, or the ability of clinicians to provide all elements of the service remotely if these services were to remain on the Medicare telehealth services list for an additional period beyond the PHE for COVID-19. Therefore, we proposed to continue including the services listed in Table 13 on the Medicare telehealth services list through the calendar year in which the PHE for COVID-19 ends. We solicited public comment on the services we identified for temporary addition to the Medicare telehealth services list through the Category 3 criteria, including whether some should not be considered as Category 3 temporary additions to the Medicare telehealth services list, or whether services currently not proposed as Category 3 additions to the Medicare telehealth services list should be considered as such. We noted that while our clinical assessment indicated that the services in Table 13 demonstrate potential likelihood of clinical benefit when furnished as telehealth services, and, as such, the potential to meet the Category 1 or Category 2 criteria for permanent addition to the Medicare telehealth services list with the development of additional evidence, we solicited information from the public that would supplement our clinical assessment and assist us in consideration of our proposals regarding the Category 3 addition of services, even though we recognize that formal analyses may not yet be available. The following are examples of the types of information we sought from the public to help inform our decisions about proposed additions under Category 3:

- By whom and for whom are the services being delivered via telehealth during the PHE;
- What practical safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth; and how are practices quickly and efficiently transitioning patients from telehealth to in-person care as needed;
- What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit;
- How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person. Certain services on the Medicare telehealth services list prior to

the PHE, specifically the O/O E/M code set, involve a physical exam. With the telehealth expansions during the PHE, clinicians may have had valuable experience providing other telehealth services to patients in higher acuity settings of care, such as an emergency department, that involve a hands-on physical examination when furnished in person.

- Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list, including whether inclusion on the Medicare telehealth services list increases access, safety, patient satisfaction, and overall quality of care;
- Whether furnishing this service or services via telecommunication technology promotes prudent use of resources;
- Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth; and
- What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list (for example, whether the health care workforce and its capabilities to provide care are expanded).

In addition, we noted that CMS is committed to the following broad goals, and these weigh heavily in our decision-making around the addition, whether temporary or permanent, of a service or services to the Medicare telehealth services list. We requested that commenters consider these goals in conjunction with their comments on the proposals for the treatment of the telehealth services we added on an interim basis during the PHE for COVID-19:

- Maintaining the capacity to enable rapid assessment of patterns of care, safety, and outcomes in the Medicare, Medicaid, CHIP, and Marketplace populations;
- Establishing system safeguards to detect and avert unintended patient harms that result from policy adjustments;
- Ensuring high quality care is maintained;
- Demonstrating ongoing quality improvement efforts by Medicare participating providers, while maintaining access to necessary care;
- Establishing protections for vulnerable beneficiary populations (those with multiple chronic conditions, functional limitations, heart failure,

COPD, diabetes, dementia), and sites of heightened vulnerability (such as nursing homes, rural communities) with high risk of adverse outcomes;

- Ensuring appropriate resource utilization and supporting cost efficiency;

- Supporting emergency preparedness and maintaining capacity to surge for potential coronavirus resurgence or other healthcare issues; and

- Considering timing and pace of policy corrections in light of local and

regional variations in systems of care and the impact of the PHE for COVID-19.

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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: Pursuant to the Full-Year Continuing Appropriations and Extensions Act, 2025, beneficiaries can continue to receive Medicare telehealth services wherever in the United States and territories they're located, including in their home, through September 30, 2025. They don't need to be in a rural area or a medical facility.

Q2: Are there any restrictions on the types of practitioners who can furnish Medicare telehealth services?

A2: Pursuant to the Full-Year Continuing Appropriations and Extensions Act, 2025, through September 30, 2025, any practitioner who can independently bill Medicare for their professional services may furnish telehealth. This includes physical therapists, occupational therapists, speech-language pathologists, and audiologists.

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: As we explained in the CY 2025 OPPS/ASC final rule with comment period, we have generally aligned payment policies for outpatient therapy services, diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services furnished remotely by hospital staff to beneficiaries in their homes with policies for Medicare telehealth services. We noted in the CY 2025 OPPS/ASC proposed rule that, to the extent therapists and DSMT and MNT practitioners continue to be distant site practitioners for purposes of Medicare telehealth services, we anticipated aligning our policy for these services with policies under the Physician Fee Schedule (PFS) and continuing to make payment to the hospital for these services when furnished by hospital staff. When the CY 2025 OPPS/ASC final rule was issued, the flexibility to allow an expanded range of practitioners to be eligible to furnish Medicare telehealth services, which included physical therapists (PTs), occupational therapists (OTs), and speech language pathologists (SLPs), was set to expire at the end of CY 2024. Consequently we stated that we would no longer pay for outpatient therapy, DSMT, and MNT services when furnished remotely by hospital staff to beneficiaries in their homes beginning in CY 2025, but we also noted that continuing to align our policies for outpatient therapy, DSMT, and MNT services when furnished by hospital staff with the Medicare telehealth policies that apply when these services are billed by the same clinicians but in private practice ensures clarity and consistency for providers and beneficiaries. The Full-Year Continuing Appropriations and Extensions Act, 2025 extended the expansion of the types of practitioners eligible to furnish Medicare telehealth services through September 30, 2025, thus enabling PTs, OTs, and SLPs to continue furnishing telehealth services through that date. CMS is continuing to align our requirements for payment for services furnished remotely by hospital staff to beneficiaries in their homes, including remotely furnished outpatient therapy services, DSMT, and MNT services, with requirements for Medicare telehealth services. Therefore, through September 30, 2025,

hospitals can continue to 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 interactive telecommunications technology is paid under the All Inclusive Rate (AIR) and Prospective Payment System (PPS), respectively. Through September 30, 2025, RHCs and FQHCs may continue to bill for non-behavioral health services furnished through interactive 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: The Full-Year Continuing Appropriations and Extensions Act, 2025, has delayed in-person visit requirements for behavioral health services for professionals billing for Medicare telehealth services until October 1, 2025. 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. Accordingly, we are also delaying the in-person visit requirements for these services until October 1, 2025. 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 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: Pursuant to the Full-Year Continuing Appropriations and Extensions Act, 2025, physicians and practitioners may continue to use two-way, real-time audio-only communication technology for Medicare telehealth services furnished through September 30, 2025. After September 30, 2025, physicians and practitioners may continue to use two-way, real-time audio-only communication technology to furnish Medicare telehealth services in accordance with the revised definition of “interactive telecommunications system”. In the CY 2025 PFS final rule, CMS permanently changed the definition of “interactive telecommunications system” to include 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 permanently receive these via audio-only communication technology. Pursuant to the Full-Year Continuing Appropriations and Extensions Act, 2025, audio-only telehealth services are permitted in all originating sites through September 30, 2025. However, in general, audio-only telehealth services are only permitted if the beneficiary is in their home. All other originating sites are medical facilities that generally have the infrastructure and broadband capacity to support two-way, audio/video communication technology. Additionally, patients would not have the same heightened expectation of privacy when video is used for a Medicare telehealth service in a medical facility as they would in their home.

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 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.

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Check for Updates



Telehealth & Remote Patient Monitoring



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What's Changed?

- We extended some telehealth flexibilities through September 30, 2025, for:
 - Originating site and using audio-only for non-behavioral and non-mental telehealth visits (page 4)
 - Medicare providers who are eligible to provide telehealth services (page 4)
 - Hospice care eligibility recertification (page 5)
 - In-person visit requirements for behavioral and mental health services (page 5)
 - Acute Hospital Care at Home Program (page 5)
 - Non-behavioral and non-mental telehealth services provided at Federally Qualified Health Centers and Rural Health Clinics (page 5)
- We removed CPT code 98016 from page 6 because it's considered a Communication Technology Based Service and isn't Medicare telehealth

Substantive content changes are in dark red.

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We pay for specific Medicare Part B services that a physician or practitioner provides via 2-way, interactive technology (or telehealth). Telehealth substitutes for an in-person visit and involves 2-way, interactive technology that permits communication between the practitioner and patient.

During the COVID-19 public health emergency (PHE), we used emergency waivers and other regulatory authorities so you could provide more services to your patients via telehealth. Section 4113 of the [Consolidated Appropriations Act, 2023](#) extended many of these flexibilities through December 31, 2024, and made some of them permanent. [Section 2207 of the Full-Year Continuing Appropriations and Extensions Act, 2025](#) extended many of these flexibilities through September 30, 2025.

Starting October 1, 2025, the statutory limitations that were in place for Medicare telehealth services before the COVID-19 PHE will retake effect for most telehealth services. These include:

- Geographic restrictions
- Location restrictions on where you can provide services
- Limitations on the scope of practitioners who can provide telehealth services

The COVID-19 public health emergency (PHE) ended at the end of the day on May 11, 2023. View [Infectious diseases](#) for a list of waivers and flexibilities that were in place during the PHE.



Originating Site

An originating site is the location where a patient gets physician or practitioner medical services through telehealth. Before the COVID-19 PHE, patients needed to get telehealth at an originating site located in a certain geographic location.

Through September 30, 2025, COVID-19 PHE telehealth flexibilities allow patients to get telehealth wherever they're located. They don't need to be at an originating site, and there aren't any geographic restrictions.

Starting October 1, 2025:

- For **non-behavioral or non-mental telehealth**, there are originating site requirements and geographic location restrictions.
- For **behavioral or mental telehealth**, all patients can continue to get telehealth wherever they're located, with no originating site requirements or geographic location restrictions. The patient's home is a permissible originating site for services provided for diagnosing, evaluating, or treating:
 - Mental health disorders
 - Substance abuse disorder
 - Monthly ESRD-related clinical assessments

Distant Site

A distant site is the location where a physician or practitioner provides telehealth. Before the COVID-19 PHE, only certain types of distant site providers could provide and be paid for telehealth. Through September 30, 2025, all providers eligible to bill Medicare for professional services can provide distant site telehealth.

Through CY 2025, distant site practitioners may continue to use their currently enrolled practice location instead of their home address when providing Medicare telehealth services from their home.

Telehealth Requirements

Technology

For most **non-behavioral or non-mental telehealth**, you must use 2-way, interactive, audio-video technology. Section 2207 of the Full-Year Continuing Appropriations and Extensions Act, 2025 allows you to use audio-only telehealth for some non-behavioral or non-mental telehealth through September 30, 2025.

As of January 1, 2025, you may also use 2-way, interactive, audio-only technology if the distant site provider is technically capable of using an audio-video telehealth system and the patient is in their home but isn't capable of, or doesn't consent to, using video technology.

For **behavioral or mental telehealth**, you may use 2-way, interactive, audio-only technology. The patient must be in their home.

Other Requirements

For Alaska or Hawaii federal telemedicine demonstrations only, you may send medical information to a physician or practitioner by telehealth to review later.

Through September 30, 2025:

- You may use telehealth to conduct hospice care eligibility recertification
- For behavioral or mental telehealth, you don't have to conduct an in-person visit within 6 months of the initial telehealth visit or annually thereafter
- We've extended the [Acute Hospital Care at Home](#) program, which heavily relies on telehealth for hospitals to provide inpatient services, including routine services, outside the hospital

Currently Covered Telehealth

- We'll temporarily suspend telehealth frequency limitations on subsequent inpatient and nursing facility visits (CPT codes 99231, 99232, 99233, 99307, 99308, 99309, and 99310) and on critical care consultations (HCPCS codes G0508 and G0509) through CY 2025
- Teaching physicians may have virtual presence when billing for services provided involving residents in all teaching settings but only in clinical situations when they provide the service virtually (for example, a 3-way telehealth visit with the patient, resident, and teaching physician in separate locations) through December 31, 2025
- For all services, we've extended the definition of direct supervision that allows the supervising physician or practitioner to provide supervision through a virtual presence using real-time audio-visual interactive telecommunications through December 31, 2025
- For a subset of services, we've permanently adopted the definition of direct supervision that allows the supervising physician or practitioner to provide supervision through a virtual presence using real-time audio-visual interactive telecommunications
- We'll continue to pay Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for:
 - Non-behavioral and non-mental telehealth services **through September 30, 2025**, using the national average payment rates for comparable services under the Physician Fee Schedule (PFS) through December 31, 2025
 - Behavioral and mental health telehealth services under the RHC all-inclusive rate (AIR) and FQHC Prospective Payment System (PPS), respectively
- We'll delay the in-person visit requirements for behavioral and mental health visits that RHCs and FQHCs provide via telecommunications technology **until January 1, 2026**

For more information on what's covered, we recommend:

- Checking the complete [List of Telehealth Services](#)
- Reviewing provider [billing and coding Medicare Fee-for-Service claims](#) for the latest telehealth guidance

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New for CY 2025

Medicare breaks down telehealth services into 2 categories—permanent and provisional. We aren't recategorizing any codes from provisional to permanent for CY 2025 because we'll conduct a comprehensive analysis of all provisional codes.

Based on several telehealth provisions in the [CY 2025 PFS final rule](#), we've added these services to the Medicare Telehealth Services List:

- Caregiver training services, which we're adding on a provisional basis
 - CPT codes 97550, 97551, 97552, 96202, and 96203
 - HCPCS codes G0539–G0543
- Pre-exposure prophylaxis (PrEP) counseling services, which we're adding permanently
 - HCPCS code G0011
 - HCPCS code G0013
- Safety planning intervention services for patients in crisis (HCPCS code G0560), which we're adding permanently

As of January 1, 2025, opioid treatment programs (OTPs) may provide the following services if all Medicare requirements are met and the applicable SAMHSA and DEA requirements permit the use of these technologies at the time the OTP provides each service:

- Periodic assessments via audio-only telecommunications
- Intake add-on code via 2-way audio-video communications technology when billed for the initiation of treatment with methadone (HCPCS code G2076) if the OTP determines they can accomplish an adequate evaluation of the patient via audio-visual telehealth platform



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Telehealth Billing & Payment

- Bill covered telehealth to your Medicare Administrative Contractor (MAC). They pay you the appropriate telehealth amount under the PFS.
- Submit professional telehealth claims using the appropriate CPT or HCPCS code.
- If you performed telehealth through asynchronous telehealth, add the telehealth GQ modifier with the professional service CPT or HCPCS code. You're certifying you collected and sent the asynchronous medical file at the distant site from a federal telemedicine demonstration conducted in Alaska or Hawaii.
- Distant site practitioners billing telehealth under the critical access hospital (CAH) optional payment Method II must submit institutional claims using the GT modifier.
- If you're located in, and you reassigned your billing rights to, a CAH and elected the outpatient optional payment Method II, the CAH bills the MAC for telehealth. The payment is 80% of the PFS distant site facility amount for the distant site service.

Place of Service Codes

Institutional Billing

Use modifier 95 for outpatient therapy services provided via telehealth by qualified physical therapists, occupational therapists, or speech language pathologists employed by hospitals.

Professional Billing

As of January 1, 2024, use:

- **Place of service (POS) 02: Telehealth Provided Other than in Patient's Home:** The location where you provide health services and health-related services, through telecommunication technology. The patient isn't located in their home when receiving health services or health-related services through telecommunication technology.
- **POS 10: Telehealth Provided in Patient's Home:**
 - The location where you provide health services and health-related services through telecommunication technology. The patient is in their home (which is a location other than a hospital or other facility where the patient gets care in a private residence) when receiving health services or health-related services through telecommunication technology.
 - As of January 1, 2024, we pay for telehealth services you provide to patients in their homes at the non-facility PFS rate. See MLN Matters® article [MM13452](#).



Telehealth Originating Site Billing & Payment

HCPCS Code Q3014 describes the Medicare telehealth originating sites facility fee. Bill your MAC for the separately billable Part B originating site facility fee. The payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80% of the lesser of the actual charge (\$29.96 for CY 2024 services and \$31.04 for CY 2025 services). We base this on the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the [Social Security Act](#). The 2025 MEI increase is 3.6%. The patient is responsible for any unmet deductible amount and coinsurance.

Note: The originating site facility fee doesn't count toward the number of services used to determine partial hospitalization services payment when a community mental health center serves as an originating site.

Telehealth Home Health

As of July 1, 2023, you must report the use of telehealth technology in providing home health (HH) services on HH payment claims. See MLN Matters article [MM12805](#) for more information.

You must submit the use of telecommunications technology on the HH claims using the following 3 HCPCS codes:

- G0320: Home health services furnished using synchronous telemedicine rendered via real-time two-way audio and video telecommunications system
- G0321: Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system
- G0322: The collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (i.e., remote patient monitoring)

When using HCPCS codes G0320–G0322:

- Report the use of remote patient monitoring that spans several days as a single line item showing the start date of monitoring and the number of days of monitoring in the Units field (G0322)
- Submit services you provide via telehealth in line-item detail
- Report each service as a separate dated line under the appropriate revenue code for each discipline providing the service
- Document in the medical record to show how telehealth helps to achieve the goals outlined in the plan of care
- Report 2 occurrences of G0320 or G0321 on the same day for the same revenue code as separate line items
- Only report these codes on type of bill 032x
- Only report these codes with revenue codes 042x, 043x, 044x, 055x, 056x, and 057x
- If more than 1 discipline is using the remote monitoring information during the billing period, home health agencies may choose which revenue code to report on the remote monitoring line item

Consent for Care Management & Virtual Communication Services

We require patient consent for all services, including non-face-to-face services. You may get patient consent at the same time you initially provide the services. We don't require direct supervision to get consent. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for these services. The person receiving consent can be an employee, independent contractor, or leased employee of the billing practitioner.

Remote Patient Monitoring

[Remote patient monitoring](#) (RPM) allows a patient to collect their own health data (for example, blood pressure) using a connected medical device that automatically transmits the data to their provider. The provider then uses this data to treat or manage the patient's condition. RPM includes both remote physiological monitoring and remote therapeutic monitoring.

- **Remote physiological monitoring** involves using non-face-to-face technology to monitor and analyze a patient's physiological metrics. Examples of physiological metrics include:
 - Oxygen saturation
 - Blood pressure
 - Blood sugar or blood oxygen levels
 - Weight loss or gain
- **Remote therapeutic monitoring (RTM)** captures non-physiological data, often self-reported, related to a therapeutic treatment. This includes data on a patient's musculoskeletal or respiratory system. RTM can also monitor treatment adherence and treatment response. A connected medical device transmits the patient's information.

RPM Requirements

- Remote physiologic monitoring, but not RTM, requires an established patient relationship
- Only physicians and non-physician practitioners eligible to provide evaluation and management services can bill RPM services
- Remote physiologic monitoring:
 - You must monitor an acute or chronic condition
 - You must collect data for at least 16 days out of 30 days (doesn't apply to treatment management codes 99457, 99458, 98980, and 98981)
- Only 1 practitioner can bill for RPM per patient in a 30-day period
- You can't bill remote physiologic monitoring and RTM together
- Monitoring must be medically reasonable and necessary
- You may bill remote physiologic monitoring and RTM, but not both, concurrently with the following care management services for the same patient if you don't count time and effort twice: chronic care management, transitional care management, behavioral health integration, principal care management, and chronic pain management
- Practitioners who aren't receiving the global periods of surgery service payment can bill for RPM services
- We require patient consent at the time you provide RPM services
- You must electronically collect physiologic data and automatically upload it to a secure location where the data can be available for analysis and interpretation by the billing practitioner
- The device used to collect and transmit the data must meet the definition of a medical device [defined by FDA](#)
- Auxiliary personnel can provide RPM services under the general supervision of the billing practitioner

RPM Components

RPM consists of 3 main components, each building off the step before it.

1. Patient education and device setup: How to use the device; how to accurately collect data
2. Device supply: Device examples; connecting the device so you can read results; how often patients should use devices
3. Treatment management: Reviewing patient data to improve patient health outcomes

RPM CPT and HCPCS Codes

CPT/HCPCS Code	Description	Time	Audio-only coverage
99091	Monthly review of data	30 minutes	N/A
99453	Initial setup and monitoring	N/A	N/A
99454	Monthly review of RPM data	16 or more days over a 30-day period	N/A
99457	Patient-provider communication related to RPM data	20 minutes	Yes
99458	Patient-provider communication related to RPM data	Additional 20 minutes	Yes
98975	RTM device setup and patient education	N/A	N/A
98976	RTM monitoring, respiratory	16 or more days over a 30-day period	N/A
98977	RTM monitoring, musculoskeletal	16 or more days over a 30-day period	N/A
98980	Patient-provider communication related to therapeutic device	20 minutes	Yes
98981	Additional time required for 98975–98978 or 90980	Additional 20 minutes	Yes

See CY 2021, CY 2022, and CY 2024 of the [PFS Final Rules](#) for more information on billing processes and policy.

Resources

- [Additional Oversight of Remote Patient Monitoring in Medicare is Needed](#) – Office of Inspector General Report
- [Medicare Claims Processing Manual, Chapter 12](#), section 190
- [Telehealth Policy Changes After the COVID-19 PHE](#)
- [Telehealth.HHS.gov](https://www.hhs.gov/telehealth)

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New Modifier for Expanding the Use of Telehealth for Individuals with Stroke

MLN Matters Number: MM10883

Related Change Request (CR) Number: 10883

Related CR Release Date: September 28, 2018 Effective Date: January 1, 2019

Related CR Transmittal Number: R2142OTN Implementation Date: January 7, 2019

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for physicians and providers billing Medicare Administrative Contractors (MACs) for stroke telehealth services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change request (CR) 10883 establishes use of a new Healthcare Common Procedure Coding System (HCPCS) modifier, G0 (G Zero), to be appended on claims for telehealth services that are furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. Make certain your billing staff is aware of this new code.

BACKGROUND



Section 50325 of the Bipartisan Budget Act of 2018 amended section 1834(m) of the Act by adding a new paragraph (6) that provides special rules for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation or treatment of symptoms of an acute stroke (acute stroke telehealth services), as determined by the Secretary. Specifically, section 1834(m)(6)(A) of the Act removes the restrictions on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished.

Section 1834(m)(6)(B) of the Act specifies that acute stroke telehealth services can be furnished in any hospital, critical access hospital, mobile stroke units (as defined by the Secretary), or any other site determined appropriate by the Secretary, in addition to the current eligible telehealth originating sites. Section 1834(m)(6)(C) of the Act limits payment of an originating site facility fee to acute stroke telehealth services furnished in sites that meet the usual telehealth restrictions under section 1834(m)(4)(C) of the Act.

In order to implement the requirements described in Section 50325 of the Bipartisan Budget Act

of 2018, Centers for Medicare & Medicaid Services (CMS) is proposing to create a new modifier that would be used to identify acute stroke telehealth services. The distant site practitioner and, as appropriate, the originating site, would append this modifier when clinically appropriate to the HCPCS code when billing for an acute stroke telehealth service or an originating site facility fee, respectively. Section 50325 of the Bipartisan Budget Act of 2018 did not amend section 1834(m)(4)(F) of the Act, which limits the scope of telehealth services to those on the Medicare telehealth list. Practitioners are responsible for assessing whether it would be clinically appropriate to use this modifier with codes from the Medicare telehealth list. By billing with this modifier, practitioners are indicating that the codes billed were used to furnish telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke.

KEY POINTS

This new modifier will be part of the annual January 2019 HCPCS update



- Effective for claims with dates of service on and after January 1, 2019, MACs will accept new informational HCPCS modifier G0 to be used to identify Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
- Modifier G0 is valid for all:
 - Telehealth distant site codes billed with Place of Service (POS) code 02 or Critical Access Hospitals, CAH method II (revenue codes 096X, 097X, or 098X); or
 - Telehealth originating site facility fee, billed with HCPCS code Q3014.

ADDITIONAL INFORMATION

The official instruction, CR10883, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2142OTN.pdf>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

DOCUMENT HISTORY

Date of Change	Description
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