HTRC Heartland Telehealth Resource Center

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Medicare Physician Fee Schedule 2026 Proposed Rule

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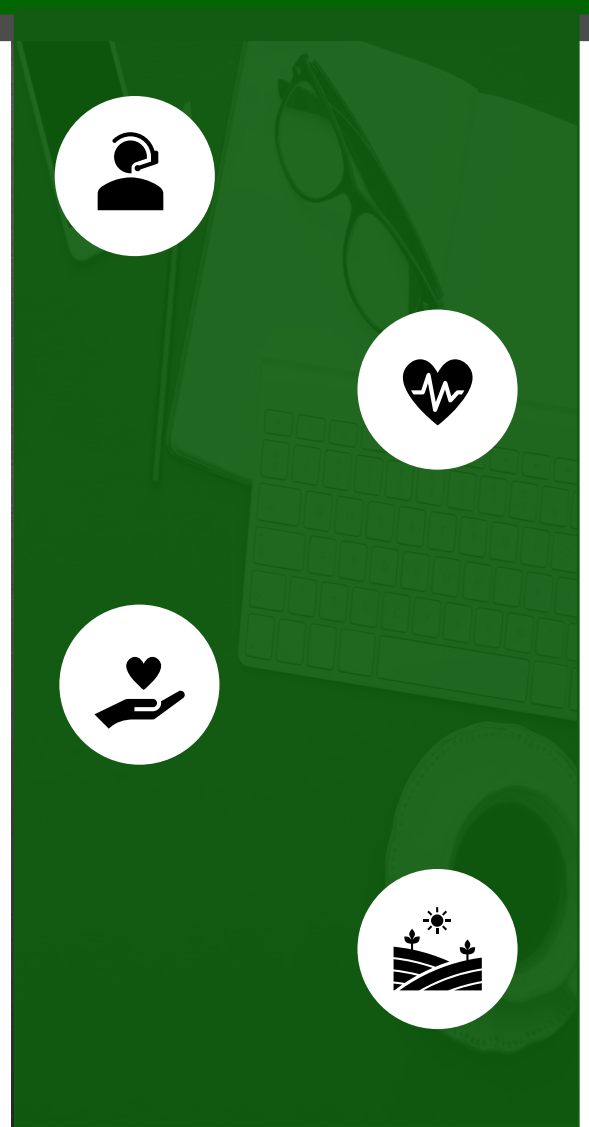
Richelle Marting is an attorney, registered health information administrator, and certified coder who focuses on healthcare coding, billing, and reimbursement issues. She has practical, in-the-trenches experience with coding and billing issues. She has served as an outpatient multi-specialty surgery coder, hospital-based outpatient coder and a compliance coordinator for a large multi-specialty medical group. As an attorney she advises clients proactively on complex reimbursement questions and has guided multiple clients through extensive Medicare and OIG audits and investigations.

The information in this session is intended to be educational and is not legal advice. No attorney-client relationship is created by way of this informational session.

HTRC Heartland Telehealth Resource Center

Overview

Telehealth Policy



Enhanced Care Management

Behavioral Health

RHC/FQHC

HTRC Heartland Telehealth Resource Center

Telehealth Requests: February 10, 2026

Go to: https://www.cms.gov/medicare/coverage/telehealth/request-addition

Each request for adding a service to the list of Medicare telehealth services must address the items outlined below.

- Contact information of the requestor. Name, Title, Organization, Email, Phone, Co-signers should include the same. We encourage collaborative submissions.
- The HCPCS code(s) that describes the service(s) proposed for addition or deletion to the list of Medicare telehealth services.
- A description of the type(s) of medical professional(s) providing the telehealth service at the distant site.
- A detailed discussion of the reasons the proposed service should be added to the definition of Medicare telehealth.
- An explanation as to why the requested service cannot be billed under the current scope of telehealth services, for example, the reason why the HCPCS codes currently on the list of Medicare telehealth services would not be appropriate for billing the service requested.
- Evidence that supports adding the service(s) to the list on either a permanent or provisional basis as explained in the section labeled “CMS Review Criteria.”

Requests are due to the CMS Telehealth Review Process mailbox no later than February 10, to be considered for the current cycle of annual notice and comment rulemaking.

Status of Telehealth Policy

- September 30, 2025 is the next major date for telehealth
- Medicare patients can receive telehealth services in their home through September 30, 2025
- There are no geographic restrictions for originating site for Medicare through September 30, 2025
- Telehealth services can be provided by all eligible Medicare providers through September 30, 2025

Status of Telehealth Policy

- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can serve as Medicare distant site providers
- An in-person visit within six months of an initial Medicare behavioral/mental telehealth service, and annually thereafter, is not required through September 30, 2025. For FQHCs and RHCs, the in-person visit requirement for mental health services furnished via communication technology to beneficiaries in their homes is not required until January 1, 2026

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- Non-behavioral/mental telehealth services in Medicare can be delivered using audio-only communication platforms through September 30, 2025. Interactive telecommunications system may also permanently 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, but the patient is not capable of, or does not consent to, the use of video technology

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Status of Telehealth Policy

- The Drug Enforcement Administration (DEA), jointly with the Department of Health and Human Services (HHS), has extended the full set of telemedicine flexibilities regarding the prescribing of controlled medications as were in place during the COVID-19 public health emergency (PHE), through December 31, 2025
- Telemedicine flexibilities regarding prescription of controlled medications include:

A DEA-registered practitioner can prescribe a schedule II-V controlled substance to a patient using telemedicine without having conducted an in-person medical evaluation if required conditions are met

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Legislation Introduced for October and Beyond

- H.R. 2263: Telehealth Coverage Act of 2025

Three tiers of professional rates are proposed for 2026

RATES

Rates

APM Participants

3.83% in conversion factor ($33.59)

Non-APM Participants

3.62% increase in conversion factor ($33.42)

Telehealth Originating Site Fee

$31.85 (up from $31.01)

Efficiency Adjustment

We are proposing to apply an efficiency adjustment to the work RVU and corresponding intraservice portion of physician time of non-time-based services that we expect to accrue gains in efficiency over time. This would periodically apply to all codes except time-based codes, such as evaluation and management (E/M) services, care management services, behavioral health services, services on the Medicare telehealth list, and maternity codes with a global period of MMM

If finalized for CY 2026, we propose to apply the efficiency adjustment to the intraservice portion of physician time and work RVUs every 3 years.

A new process is proposed to determine whether services qualify for the Medicare list of covered telehealth services

TELEHEALTH

Telehealth: Revising the Review Process

We are proposing, beginning for the CY 2026 Medicare Telehealth Services List, to revise the 5-step review process for reviewing requests to the Medicare Telehealth Services List. Based on feedback from interested parties, we believe that we need to simplify our telehealth list review process by focusing our review on whether the service can be furnished using an interactive telecommunications system

“based on feedback from interested parties and our own internal review, the 5-step process insufficiently accounts for the vital role of professional judgment exercised by physicians and other practitioners”

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

We therefore are proposing to remove Step 4 (Consider whether the service elements of the requested service map to the service elements of services on the list that has a permanent status described in previous final rulemaking) and Step 5 (Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at a distant site using an interactive telecommunications system) from our review criteria

Under this proposal, services on the Medicare Telehealth Services List would no longer be designated "permanent" or "provisional".

All services listed or added on the Medicare Telehealth Services List would be considered included on a permanent basis

- If finalized, all codes currently on the list (provisional or permanent) will remain on the Medicare Telehealth Services List
- We strive to balance the goals of increasing practitioner and patient choice of service modality with the consideration of patient safety for all Medicare beneficiaries

! Notably, the addition of a service to the Medicare Telehealth Services List does not mean that it is appropriate to be furnished via telehealth to every Medicare beneficiary in every clinical scenario

! We believe physicians and other practitioners would **consider important safety factors** when determining the appropriate service modality for their specific beneficiaries. We continue to encourage the review and use of **clinical practice guidelines, peer-reviewed literature**, and similar materials that illustrate the typical setting of care, population of beneficiaries, and clinical scenarios that practitioners would encounter when furnishing the Medicare Telehealth service using only interactive, two-way audio-video communications technology or two-way, real-time audio-only communication technology for services furnished to a patient in their home

List of Covered Telehealth Services

In contrast to prior years, CMS proposes to add several services that were submitted for consideration to add to the list of covered telehealth services.

CPT telehealth codes that were new in 2025 were proposed to be added as covered telehealth services, but denied, because they are not recognized by Medicare for payment

TABLE 8: CY 2026 REQUESTS FOR ADDITION TO THE MEDICARE TELEHEALTH SERVICES LIST

✓ CMS Proposes to Add

Category	HCPCS	Short Descriptor
Multiple-Family Group Psychotherapy	90849	Multiple family group psytx
Group Behavioral Counseling for Obesity	G0473	Group behave couns 2-10
Infectious Disease Add-On	G0545	Inherent visit to inpt
Auditory Osseointegrated Sound Processor	92622	Dx aly aud oi snd prcsr 1st
	92623	Dx aly aud oi snd prcsr each
Dialysis	90935	Hemodialysis one evaluation
	90937	Hemodialysis repeated eval
	90945	Dialysis one evaluation
	90947	Dialysis repeated eval
Telemedicine E/M	98000	Synch audio-video new sf 15
	98001	Synch audio-video new low 30
	98002	Synch audio-video new mod 45
	98003	Synch audio-video new hi 60
	98004	Synch audio-video est sf 10
	98005	Synch audio-video est low 20
	98006	Synch audio-video est mod 30
	98007	Synch audio-video est hi 40
	98008	Synch audio-only new sf 15
	98009	Synch audio-only new low 30
	98010	Synch audio-only new mod 45
	98011	Synch audio-only new high 60
	98012	Synch audio-only est sf 10
	98013	Synch audio-only est low 20
	98014	Synch audio-only est mod 30
	98015	Synch audio-only est high 40
Home INR Monitoring	G0248	Demonstrate use home INR mon

Telehealth Frequency Limits

We believe that physicians and other practitioners, who have the greatest familiarity and insight into the needs of individual beneficiaries, can use their complex professional judgment to determine whether they can safely furnish a service via telehealth given the entirety of the circumstances, including the clinical profile and needs of the beneficiary, to determine the appropriate service modality

Notably, the removal of these frequency limitations does not mean that these services are appropriate to be furnished via telehealth to every Medicare beneficiary in every clinical scenario

Direct Supervision via Telehealth

We are proposing to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for all services described under § 410.26, except for services that have a global surgery indicator of 010 or 090

- Similar to our guidance above regarding Medicare Telehealth services, services, our proposed definition of direct supervision (allowing "immediate availability" of the supervising practitioner using audio/video real-time communications technology does not mean that it is appropriate to allow virtual presence for every service for every Medicare beneficiary in every clinical scenario)

Direct Supervision via Telehealth

We are seeking comment on whether to adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for all services described under § 410.26, except for services that have a 000, 010, or 090 global surgery indicator.

Direct Supervision via Telehealth

We are **not proposing to extend** our current policy to allow **teaching physicians to have a virtual presence** for purposes of billing for services furnished involving residents in all teaching settings through December 31, 2025, but **only when the service is furnished virtually** (for example, a 3-way telehealth visit, with the patient, resident, and teaching physician in separate locations).

As always, documentation in the medical record must continue to demonstrate whether the teaching physician was physically present or present through audio/video real-time communications technology at the time of the Medicare telehealth service, which includes documenting the specific portion of the service for which the teaching physician was present through audio/video real-time communications technology

Evaluation and Management Services

We are proposing to allow HCPCS code G2211 to be billed as an add-on code with the home or residence evaluation and management visits code family (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350)

For CY 2026, we are proposing to create optional add-on codes for APCM services that would facilitate providing complementary BHI services by removing the time-based requirements of the existing BHI and CoCM codes.

Evaluation and Management Services

These proposed optional add-on codes for APCM services would be considered a ‘‘designated care management service’’

As such, could be provided by auxiliary personnel under the general supervision of the billing practitioner

Evaluation and Management Services

We are **seeking comments on** cost sharing for APCM services, particularly, if we were to include preventive services within the APCM bundles. How should we account for cost sharing if APCM includes both preventive services and other Part B services?

Should CMS consider including the Annual Wellness Visit, depression screening, or other preventative services in the APCM bundle, and if so, which services and why?

Comment Solicitation on Payment Policy for Software as a Service (SaaS)

- These costs are not well accounted for in the PE methodology
- interested parties have stated that the lack of a consistent payment policy for SaaS and AI devices is an impediment to patient access when these devices are otherwise cleared, approved, or authorized by the FDA.

RFI on Prevention of Chronic Disease

- How could we better support prevention and management, including self-management, of chronic disease?
- Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, please provide specific examples.
- Are there current services being performed to address social isolation and loneliness of persons with Medicare, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, what evidence has supported these services, and what do these services entail? What services have been delivered by Medicare providers or community-based organizations, including area agencies on aging and other local aging and disability organizations? What has been the impact?

We are soliciting feedback from the public regarding motivational interviewing and health coaches

- Please provide information on whether we should create separate coding and payment for motivational interviewing, or whether the resources involved in furnishing these services are appropriately recognized in current coding and payment.
- What is the best definition and description of motivational interviewing?
- What types of clinical staff should be able to perform motivational interviewing under the general supervision of a billing practitioner?
- How long does a session of motivational interviewing typically last? If we were to create coding and payment for motivational interviewing, what should the time-based requirements of the code be?
- We heard from interested parties that in many clinics, health coaches perform services under general supervision, and that there may be substantive overlap with motivational interviewing. To what extent are the services performed by health coaches encompassed by motivational interviewing?
- What training is required to effectively perform motivational interviewing? Are there agreed upon national training or certification standards for health coaches? If so, what are they? Do states have separate training or certification standards for health coaches?
- To what extent would health coaches be able to perform motivational interviewing incident-to billing practitioners under general supervision? Please see § 410.26(a)(3) for further information about general supervision.

RHC, FQHC

We are proposing to require **RHCs and FQHCs to report the individual codes** that make up the CoCM HCPCS code, G0512 beginning January 1, 2026.

We are proposing to require **RHCs and FQHCs to report the individual codes that make up HCPCS code G0071** (Payment for communication technology-based services for 5 minutes or more) beginning January 1, 2026. **Payment** for these services will be based on the **national non-facility PFS payment rate**.

We think **direct supervision provided via two-way real time audio-video telecommunications** technology meets the statutory requirements specific to RHCs and FQHCs at section 1861(aa)(2)(B) of the Act regarding necessary physician supervision and guidance.

“Direct Supervision” would mean that the physician (or other supervising practitioner) must be present in the RHC or FQHC and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the physician (or other supervising practitioner) must be present in the room when the service is performed. **The presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only).**

RHC, FQHC as Distant Site Billers of Telehealth

If Congress no longer authorizes payment to be made for telehealth services furnished via a telecommunications system by RHCs and FQHCs using a payment methodology based upon payment rates that are similar to the national average payment rates for comparable telehealth services under the PFS, **we are proposing**, on a temporary basis, **to facilitate payment for** non-behavioral health visits (hereafter referred to in this discussion as **"medical visit services"**) furnished via telecommunications technology using an approach that closely aligns with this methodology.

RHCs and FQHCs would continue to bill for RHC and FQHC medical visit services via **telehealth**, including services furnished using audio-only communications technology, **by reporting HCPCS code G2025 on the claim.**

Questions?

*This presentation was made possible by grant number **U1UTH42530** from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS*

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