



Date: September 23, 2025

To: All Providers, APPs, Clinical Staff, Scheduling, Billing & Coding

From: Medical Director & Coding Director

Subject: Telehealth Changes Effective October 1, 2025

Bottom line

After Oct 1, assume all payors will no longer cover Telehealth. You may continue to prescribe over tele-health through the end of the year, but you will not get paid for the visit.

Context

Effective **September 30, 2025**, the temporary Medicare telehealth flexibilities that began during the COVID-19 Public Health Emergency officially **expired**. Beginning **October 1, 2025**, Medicare coverage reverts to **pre-pandemic rules** unless Congress enacts new legislation. While there are bills pending in Congress (e.g., Telehealth Modernization Act, CONNECT Act), as of this date **no law has been passed** to extend or make telehealth flexibilities permanent.

These changes impact **originating site requirements, provider eligibility, modality rules, FQHC/RHC reimbursement, and audio-only allowances**. Please read carefully to understand the updates and how they affect IPM workflows.

Why this matters

During the pandemic, Medicare and many payers relaxed telehealth rules (home as originating site, no rural-only limits, more audio-only). Most of these flexibilities **end after September 30, 2025**, for **non-behavioral** services unless a payer explicitly extends them. All practices rely on telehealth for consults, med management, and post-op follow-ups, so workflows and documentation must change.

What changes on October 1, 2025 (Medicare FFS)

1. **Originating site / geography return**
 - For most **non-behavioral** services, patients will generally **need to be at an approved originating site** (e.g., clinic, hospital, RHC/FQHC) and typically in a **rural** area. Home-based telehealth will **not** be broadly allowed.
2. **Modality**
 - **Audio-video** is required for most non-behavioral services. **Audio-only** is limited (primarily behavioral health and narrow exceptions). Avoid audio-only unless documentation supports it.



3. Behavioral health stays more flexible

- Tele-psych and related behavioral services retain **home** as site and **audio-only** options when criteria are met. Use this for pain psychology/counseling.

4. Place of Service (POS)

- Continue to use:
 - **POS 10** – Telehealth **from patient's home**.
 - **POS 02** – Telehealth **other than home** (e.g., patient at a clinic).
- Follow Medicare guidelines until further notice as some will diverge from Medicare FFS.

5. Modifiers

- **Modifier 95** (audio-video) is often **not required by Medicare FFS**, but many **commercial/MA/Medicaid plans still require it**.
- **Modifier 93** = **audio-only** synchronous telehealth where allowed.

6. CPT coding

- **Use standard E/M codes** for audio-video telehealth. New CPT "telemedicine" labeling exists, but Medicare FFS did **not** adopt new audio-only E/M codes; the old phone-only codes (99441–99443) were deleted by CPT.

7. Controlled substances (DEA)

- Tele-prescribing flexibilities are evolving. Special registration pathways are being created for tele-prescribing **Schedule III–V** without prior in-person eval if criteria are met; **Schedule II** is more restricted. Expect payer/pharmacy variance. **When in doubt, plan for in-person evaluation.**

Recommended Practice Policy (effective Oct 1, 2025)

1. Visit types allowed via telehealth (by default)

- **Audio-video only**: pre-procedure consults without physical exam needs; imaging review; routine med checks (non-controlled when feasible); simple post-op checks; DME reviews.
- **Behavioral health**: pain psychology, coping skills, CBT-I—home site allowed; audio-only when policy criteria met.
- **Audio-only** for IPM is **discouraged** and requires payer verification + documentation of **why video wasn't possible**.



2. Scheduling rules

- If telehealth is requested, schedulers must capture **patient location at time of service** and **payer**. If Medicare FFS and non-behavioral, schedule at an **approved originating site** (clinic or partner site) or convert to **in-person**.

3. Documentation checklist (must-have fields)

- Patient **location** at time of service; if audio-only, reason video unavailable and **patient consent**.
- **Modality** (AV vs AO), **platform**, **participants**, **time** (if time-based coding).
- For behavioral health: note that service qualifies; document **risk/benefit** and **tech limitations** if AO.

4. Coding & billing

- **POS**: use **10** (home) only when policy allows; otherwise, **02** when patient is at a clinic/approved site.
- **Modifiers**:
 - Use **95** if required by the plan (commercial/MA/Medicaid); omit for Medicare FFS AV unless future guidance changes.
 - Use **93** strictly for **audio-only** when plan permits.
- **CPT**: bill standard E/M (99202–99205, 99211–99215) for AV telehealth.

5. Medications / controlled substances

- For **Schedule II** or complex opioid management, default to **in-person** evaluation unless a documented tele-prescribing pathway exists for that patient/payer/pharmacy. Coordinate with RCM and pharmacy before issuing.

Workflow updates (action items)

- **Scheduling script (start Sept 24):**
 - 1) “Is your visit behavioral health (pain psychology)?” If **yes**, tele-health from home is generally ok.
 - 2) If **no**, “Are you on Medicare?” If **yes**, schedule at our **clinic** (POS 02) for telehealth or convert to in-person.
 - 3) If commercial/MA/Medicaid: use **home** only when allowed; capture required modifiers.
- **EHR template fields (add by Sept 26):** Patient Location (home/clinic/address), Originating Site (if not home), Modality (AV/AO), Reason for AO, Consent, Time, Tech issues.
- **Charge slips update (by Sept 27):** POS 02/10 radio buttons; Modifiers 95/93 checkboxes.
- **RCM audit (Oct–Nov):** 5% sample of telehealth claims for correct POS/modifiers and payer-specific rules; immediate feedback to providers.
- **Patient comms:** Update website and reminder texts: “Some telehealth visits now require you to be at a clinic site. We’ll guide you when you schedule.”



Quick reference table

Scenario	Site	POS	Modifiers	Notes
Medicare FFS, pre-op consult (non-behavioral)	Clinic	2	(95 only if payer requires; Medicare FFS typically not required)	Use AV; avoid AO.
Medicare FFS, pain psychology	Home	10	95 if plan requires; 93 if audio-only allowed & documented	Behavioral health retains home & AO options.
Commercial plan allows home AV	Home	10	95 (plan-specific)	Confirm plan policy.
Commercial plan clinic AV	Partner clinic/Clinic	2	95 (often)	Keep site proof in chart.
Any plan, audio-only exception	Home/Clinic	10 or 02	93	Document inability to use video + consent + medical necessity.

FAQs

Q: Can we keep doing home-based telehealth for routine IPM follow-ups?

A: For **Medicare FFS non-behavioral**, generally **no** after Oct 1 unless an exception applies. Many commercial/MA/Medicaid plans may still allow it.

Q: Do we still use modifier 95?

A: Depends on payer. Medicare FFS often does **not** require 95 for AV telehealth; many commercial/MA/Medicaid plans **do**.

Q: What about new CPT telemedicine codes?

A: Use standard E/M for AV telehealth with Medicare FFS. The **new audio-only E/M codes aren't adopted by Medicare FFS**.

Q: How do we handle controlled substance refills?

A: Expect stricter pathways. When uncertain, schedule **in-person**. If tele-prescribing is used, ensure eligibility, pharmacy acceptance, and full documentation.

— End of Memo —