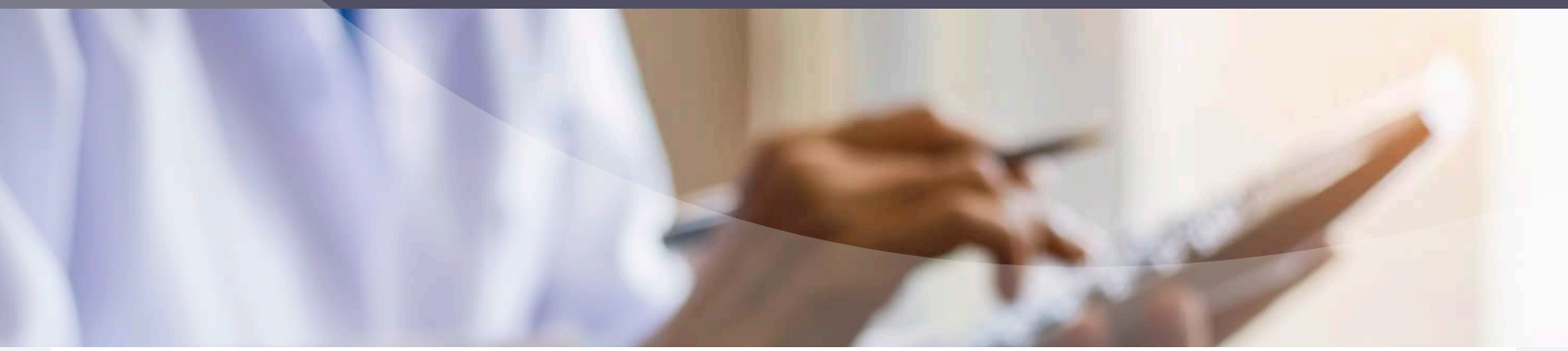
Final CY 2026 MEDICARE PHYSICIAN FEE SCHEDULE

FACT SHEET I November 2025

On October 31, 2025, the Centers for Medicare and Medicaid Services (CMS) released their final rule for the 2026 Physician Fee Schedule (PFS). Each year, the agency uses the PFS to update, change or introduce new policies that will impact the Medicare program for the following year. Unless otherwise stated, the policies will typically go into effect the first of the year. What follows are the proposals that directly relate to telehealth. Please note that the page numbers referenced below refer to the *unpublished version of the proposed 2026 PFS*.



Medicare Telehealth Services List: Revised Code Evaluation Process & Proposed Newly Eligible Services

(p. 136)

CMS finalized the change to their process regarding how they decide which services will be placed on the Medicare Telehealth Services List. Each year during the PFS process, CMS both makes their own recommendations on the services that should be added to the list, as well as receives recommendations from the public. Previously, each proposed service would go through a five-step evaluation process and CMS would use that process to determine if the code should be denied from being on the list of eligible telehealth services in Medicare, or if it should be placed on the list in either a "permanent" or "provisional" status. The new finalized process is now reduced to only three steps:

- Determine whether the service is separately payable under the PFS.
- Determine whether the service is subject to the provisions of section 1834(m) of the Social Security Act.
- Review the elements of the service as described by the HCPCS code and determine whether each is capable of being furnished using an interactive telecommunications system as defined in 42 CFR § 410.78(a)(3).

Additionally, within this revised evaluation process, the assigned status of the code as either "permanent" or "provisional" is now eliminated. If the code makes it through this three-step process and is approved by CMS, it will be placed on the eligible telehealth services list with no status designation, though CMS would still retain the ability to remove the code at a future date based upon an internal review or feedback from the public. CMS writes that this streamlined process will allow the agency to focus their decisions around whether or not to approve the addition of a service for the Medicare Telehealth Services List on whether the service can be provided via an interactive, two-way audio-video telecommunications system.

With this new process finalized, codes currently on the eligible telehealth services list that are in a "provisional" status will remain on the Medicare Telehealth Services List, without the need for further review and will no longer be labeled as provisional.

In addition to this procedural change, CMS is proposing the addition of certain codes to the Medicare Telehealth Services List. Of the codes the public suggested be added to the list of eligible codes, CMS has decided to finalize the rule to add these five codes:

HCPCS	SHORT DESCRIPTION
90849	Multiple family group psytx
G0473	Group behavioral counseling 2-10
G0545	Inherent Visit to inpt
92622 & 92623	Diagnostic analysis, programming and verification of an auditory osseointegrated sound processor

CMS notes that based on their revised three-step process in evaluating which codes to add to the permanent list, the five codes listed above do pass the test.

CMS declined to add dialysis codes 90935, 90937, 90945, and 90947 due to insufficient information needed to determine if these codes would pass Step 3 in their evaluation. CMS was unclear on how telehealth would be used in providing these services and in which clinical circumstances the services would be furnished via telehealth.

CMS is also declining to add G0248 to the list of eligible services because the service is not typically provided by a physician or a practitioner, rather it is a technical part of the service delivered by clinical staff connected to the supplier. CMS notes these types of services are separate from the professional services to which the telehealth policies are meant to apply, and therefore would not meet Step 2 in their review process.

CMS is also declining to add Telemedicine E/M codes 98000-98015 to the eligible telehealth services list, as it did in the 2025 PFS. These are the telemedicine codes created by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel in 2023. Within the 2025 PFS, CMS added 98016 in place of G2012. At the time, CMS noted that G2012 was not a code on the eligible telehealth services list as G2012 was a communication technology-based service (CTBS) code. Here, CMS makes a similar observation for 98000-98015, noting that they are not separately payable under the Medicare physician fee schedule when furnished in-person, and therefore would fail Step 1 of their review process. To be on the eligible telehealth services list, the code must also be one that is already being reimbursed by Medicare.

In a related clarification, CMS also addressed questions it received regarding Digital Mental Health Treatment (DMHT), Remote Physiologic Monitoring (RPM), and Remote Therapeutic Monitoring (RTM) services. CMS emphasizes that these services, which are inherently non-face-to-face, do not meet the statutory definitions for telehealth and therefore fall outside the scope of Medicare telehealth services.

As such, they do not meet Step 2 of the review process and are not subject to the telehealth provisions under 1834(m).

Due to public comments opposing the initial proposal to delete G0136 from the Medicare Telehealth Services List, CMS did not finalize its original proposal, and G0136 will remain on the Medicare Telehealth Services List.

CMS also writes that should anyone wish to submit codes for consideration for inclusion on the 2027 Medicare Telehealth Services List they must do so by February 10, 2026. See CMS Requests for Additions page for further information and instructions on submissions.

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Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations (p. 154)

In the 2026 PFS, CMS has finalized their rule to permanently remove frequency limitations on the following codes:

HCPCS	SHORT DESCRIPTION
99231-99233	Subsequent Inpatient Visit CPT Codes
99307-99310	Subsequent Nursing Facility Visit CPT Codes
G0508 & G0509	Critical Care Consultation Services: HCPCS Codes

Direct Supervision via use of a Two-Way Audio-Video Communication Technology (p. 158)

In previous iterations of the PFS, CMS has allowed for limited and temporary use of telehealth to meet direct supervision requirements. CMS is finalizing their proposal to permanently adopt a definition for "immediate availability" of the supervising practitioner using audio-video real-time communication technology (audio-only is excluded) for all services described in 42 CFR Section 410.26 except for those services that have a global surgery indication (when some type of surgery occurred) of:

- **010** - Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable) or

- **090** - Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

The exclusion of the services in 010 and 090 is to ensure quality of care and patient safety by not compromising the supervising practitioner's ability to intervene if complications arise. CMS also sought comments regarding applying the "immediate availability" definition to services that have a 000 global surgery indicator, as well as additional services under 42 CFR Section 410.32. After receiving comments, CMS has finalized their proposal to not exclude services with a 000 global surgery indicator and allow the physician or practitioner to have a virtual presence through audio/video real-time communications technology (audio-only is excluded) for 42 CFR Section 410.26 and 42 CFR Section 410.32 services without a 010 or 090 global surgery indicator.

Direct Supervision of Residents (p. 165)

The current temporary policy allows for a teaching physician to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only when the services are furnished virtually. For the 2026 PFS, CMS proposed to end this policy with the exception of services provided outside of a Metropolitan Statistical Area (MSA). In their proposal, CMS wrote: "In these rural settings, teaching physicians may continue utilizing audio/video real-time communications technology to fulfill the presence requirement, provided they maintain active, real-time observation and participation in the service." Additionally in the proposal, virtual supervision by teaching physicians for educational purposes could continue. However, after receiving public comments, CMS has decided to permanently adopt the policy without the MSA exclusion, allowing teaching physicians to have a virtual presence in all teaching settings, but in clinical instances, the virtual presence is allowed only when the services are provided virtually (teaching physician, resident and patient in different locations in a 3-way telehealth visit).

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) (p. 674)

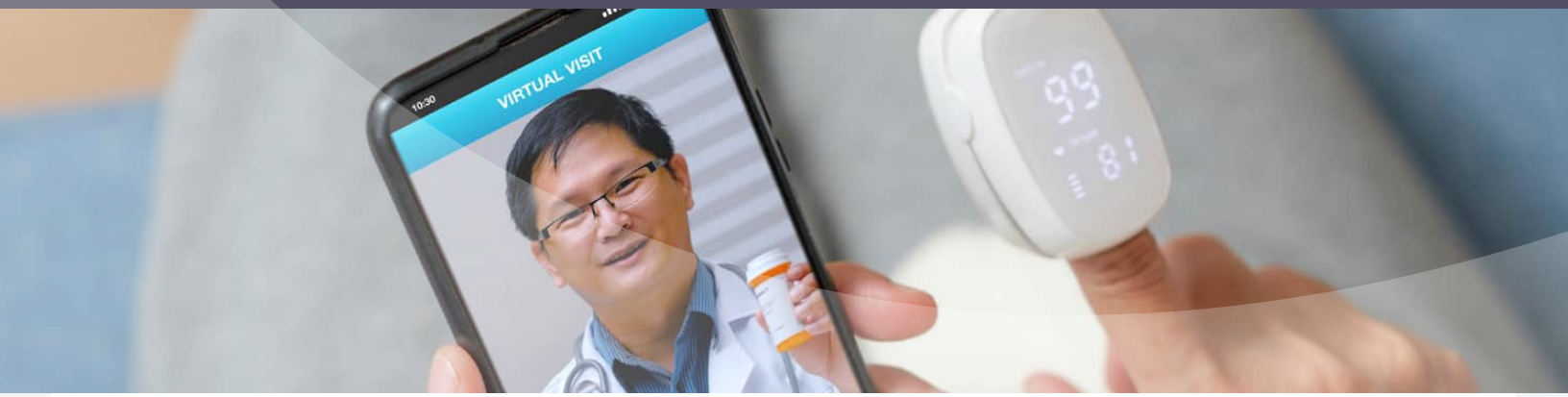
CMS will extend for one additional year the ability for FQHCs and RHCs to bill for medical visit services (non-behavioral health services) provided via telecommunications technology, including those furnished via audio-only. FQHCs and RHCs should continue to use G2025 through December 31, 2026, and the payment amount will continue to be calculated based on the PFS and weighted by volume, not the FQHC/RHC's regular Prospective Payment System (PPS) rate or All-Inclusive Rate (AIR). While CMS considered revisions that would allow medical visit services furnished via telecommunication technology to be paid at PPS/AIR rates, similar to allowances for mental health visits, they determined this route may lead to additional cost pressures.

As a reminder, in the 2022 PFS, CMS made the ability for FQHCs/RHCs to provide mental health visits via telecommunications technology permanent, if FQHCs/RHCs meet prior and subsequent in-person visit requirements. While the 2025 PFS delayed the in-person requirements for FQHCs/RHCs through the entirety of 2025, CMS had proposed in July that they would be updating that policy in the 2026 PFS to be consistent with federal statutory waivers of general telemental health in-person requirements, which expired with the end of the temporary Medicare waivers on September 30, 2025. In this final rule for 2026, CMS finalized their initial proposal and now requires for mental health services provided by an FQHC/RHC via telecommunications technology, starting October 1, 2025, that an in-person mental health service be furnished within 6 months prior to the furnishing of telecommunications service and also every 12 months thereafter while the patient is receiving services via telecommunications technology, unless the provider and patient agree that the risks and burdens of meeting this requirement outweigh the benefits with doing the in-person visit. (p. 677).

Advance Primary Care Management (APCM) & Behavioral Health Integration/Collaborative Care Model (p. 644)

For Advance Primary Care Management (APCM), CMS finalized their proposal to adopt add-on codes that would facilitate Behavioral Health Integration (BHI) and Collaborative Care Model (CoCM) services for FQHCs and RHCs. If furnishing APCM services, FQHCs and RHCs may report G0568, G0569 or G0570 when they integrate behavioral health services with these services. In line with this change, CMS is unbundling G0512 and FQHCs and RHCs will be required to report the individual codes (see below) that make up G0512 beginning January 1, 2026.

CODES THAT MAKE UP G0512	
HCPCS/CPT CODE	**SHORT DESCRIPTION**
99492	1st psych collab care mgmt.; CoCM First Month, 70 minutes per calendar month
99493	Sbsq psyc collab care management; CoCM Subsequent Months, 60 minutes per calendar month
99494	1st/subesq psyc collab care; Add-on CoCM (any month), each additional 30 minutes per calendar month.
G2214	Init/sub psych care m 1st 30; Initial or subsequent psychiatric collaborative care management, 30 minutes of behavioral health care manager time per calendar month.



Payment for Communication Technology-Based Services (CTBS) and Remote Evaluation (p. 656)

CMS finalized its proposal to require FQHCS and RHCs to report the individual codes that make up G0071 starting January 1, 2026. Payment for these services will be based on the non-facility PFS payment rate. CMS took this action due to the similarities of APCM containing elements of CTBS and remote evaluation services, but CMS had not yet directed FQHCs and RHCs on how to avoid duplication of these services in their billing. Therefore, they felt this action was required. The codes that are to be used in reporting these individual services are:

CTBS & REMOTE EVALUATION CODES TO USE	
HCPCS/CPT CODE	**SHORT DESCRIPTION**
G0071	Communication Services by RHC/FQHC 5 minutes
G2010	Remote image submit by patient
G2012	Discontinued - Brief check in by MD/QHP
G2250	Remote image submitted by patient, non-E/M
98016	Brief communication technology-based service

Other FQHC/RHC Related Final Rules

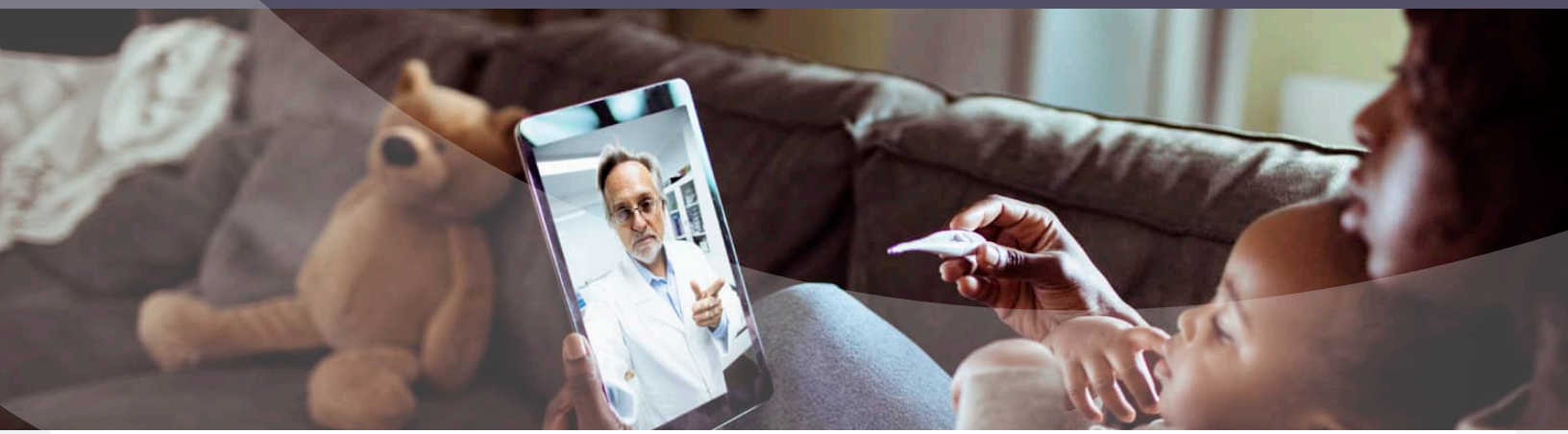
- When CMS finalizes proposals to adopt services that are established and paid under the PFS and classified as care management services, they will also be adopted as care coordination services for the purpose of separate payment for FQHCs and RHCs. Additionally, proposals related to care management that are finalized via the PFS, CMS will update FQHC/RHC policy through sub-regulatory guidance (bulletins, manual updates, etc.) rather than the full regulatory process. (p. 661)
- A change in definition for “direct supervision” to mean the physician or other supervising practitioner must be present in the FQHC/RHC (but not in the same room as the service) and immediately available to furnish assistance and direction through the performance of the service to include virtual presence through audio-video real-time communication (excludes audio-only). (p. 671)

Ambulatory Specialty Model (ASM) (p. 680)

The Ambulatory Specialty Model (ASM) is a new model that would focus on low back pain and congestive heart failure. The goal of the model is to prevent worsening or reoccurrence of chronic conditions, and improve chronic disease management and early detection. More information on the model can be found in the Ambulatory Specialty Model page. In this model, certain permanent Medicare telehealth policies are to be waived, namely the geographic and site requirements. Additionally, ASM participants will be allowed to bill established G-codes and when furnishing a telehealth service to a beneficiary in their home, the ASM participant would not be permitted to bill for telehealth services not fully furnished due to a technical issue.

Additional Finalized Rules

- Telehealth originating site fee of $31.85 (p. 170)
- For Digital Mental Health Treatment (DMHT), CMS finalized payment for DMHT devices for Attention Deficit Hyperactivity Disorder (ADHD), as proposed. CMS clarifies the patient must have a mental health condition diagnosis, but the billing practitioner does not need to be the practitioner who made the diagnosis. (p. 439)
- New codes have been created for both Remote Therapeutic Monitoring (RTM) and Remote Physiological Monitoring (RPM) for less than 16 days of data transmission per 30-day period and less than 20 minutes of interactive communication per month: 98984, 98985, and 98979 (RTM), 99445 and 99470 (RPM). (p. 331)
- Several definition changes to the Medicare Diabetes Prevention Program (MDPP) were made that extend virtual delivery flexibilities through December 31, 2029. CMS is also adding coverage for asynchronous online delivery of MDPP through December 31, 2029. (p. 1110)



- While not presented as a proposal for this PFS, CMS did receive comments raising concerns that providers using their home address as their location could now consequently have that information accessed publicly. CMS chose not to extend the allowance this time for distant site providers to continue to use their 2025 enrolled practice location address instead of their home address, however CMS notes that they issued an FAQ on how to suppress that information. CMS also states that they defer to each state's policies regarding licensure requirements for distant site Medicare telehealth providers and that a separate Medicare enrollment is required for each state in which the provider furnishes services. (p. 172).

Analysis

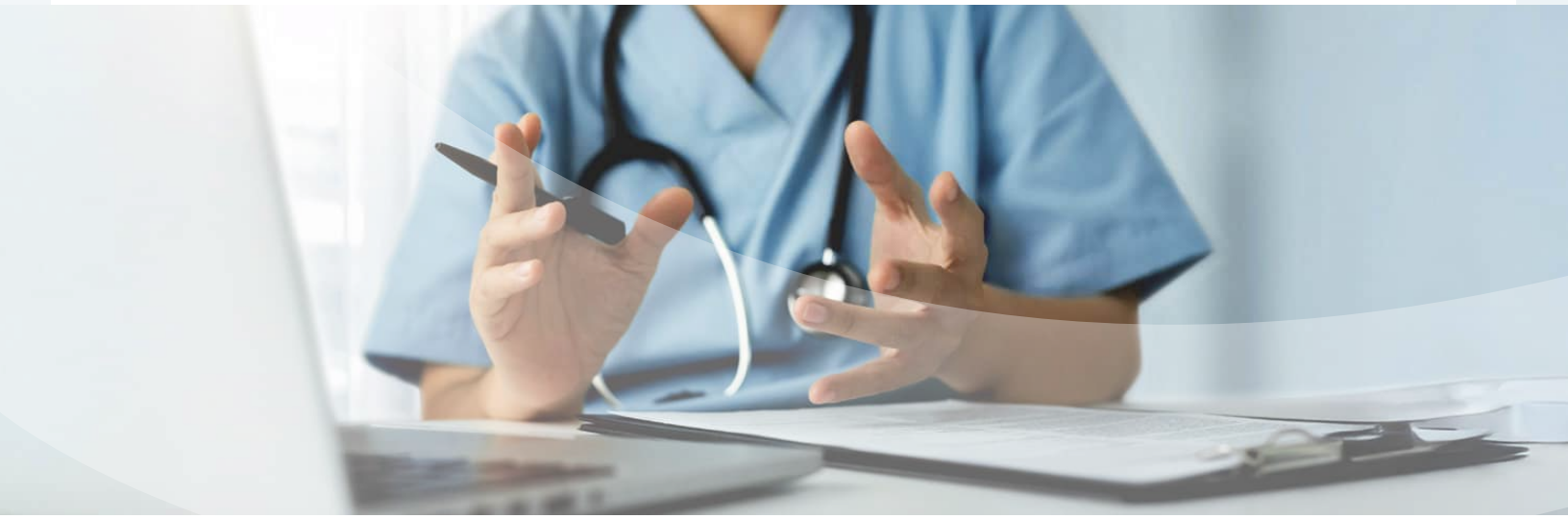
Similar to most previous PFS processes, CMS finalized the majority of their proposals that had been made earlier this year. One exception is the removal of G0136 from the Medicare Telehealth Services List. CMS had originally proposed removing G0136 from the list of eligible services, however, due to public comment, CMS is not going forward with their original proposal and G0136 will remain on the list. Second, CMS had originally proposed ending their temporary policy of allowing a virtual presence by a teaching physician in all teaching settings regardless of geographic location, only in clinical instances when the service is furnished virtually. The proposed policy would have reverted back to the original policy, which would allow the virtual presence option to be used for services provided outside of an MSA only. However, again after reviewing public comments, CMS has decided it will instead be permanently adopting the current telehealth-only rule. Which means that teaching physicians can continue to have a virtual presence, regardless of geography, and in clinical instances when the services are provided virtually (a three-way telehealth interaction where patient, resident and teaching physician are in different locations). CMS's original proposal to eliminate this temporary policy had raised concerns among many stakeholders due to the impacts on communities that would lose this alternative option. Therefore, both of these examples showcase the ability of public comments to influence and shape policy.

Other policies proposed by CMS were finalized without changes, including extending by one-year, to December 31, 2026, an FQHC and RHC's ability to provide medical services via telecommunications

technology – regardless of what may or may not happen with any Medicare telehealth waivers passed by Congress. CMS finalized a similar regulation for the 2025 PFS, so even without the temporary telehealth waivers in place as of October 1, 2025, FQHCs and RHCs are still able to provide services via telecommunications technology, as these policies are not considered "telehealth" from CMS' perspective.

One additional policy that was finalized intact was the alignment CMS noted that it would make with the policies passed by Congress regarding in-person visits for mental health services. Under the Medicare telehealth waivers, Congress had temporarily suspended the required in-person visits for mental health services that did not meet certain location requirements nor fit into one of the narrow exceptions to meeting these requirements under permanent telehealth Medicare policy. This exception in Medicare expired on September 30, 2025. In the 2025 PFS, CMS had originally waived the in-person requirements for mental health visits provided via telecommunications technology by FQHCs and RHCs through December 31, 2025, however in their 2026 PFS proposals, they instead noted that they intend to align with the policies passed by Congress. Therefore, in this now final rule in the 2026 PFS, CMS made changes to the applicable regulations and noted that beginning October 1, 2025, similar to non-FQHC/RHC providers, FQHCs/RHCs now need:

> *An in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications services and that an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months while the beneficially is receiving services furnished via telecommunications technology for the diagnosis, evaluation, or treatment of mental health disorders, unless for a particular 12 month period, the physician or practitioner and patient agree that the risks and burdens outweigh the benefits associated with the furnishing the in-person item or service, and the practitioner documents the reasons for this decision in the patient's medical record.*



This application contradicts what CMS had previously written in their FAQ on telehealth in Medicare dated October 1, 2025 (and released to the public on October 15, 2025) which stated, "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 at least until January 1, 2026." However, now given that the final 2026 PFS made actual changes to the Code of Federal Regulations (CFR) to reflect the October 1, 2025 date, that will take precedence over the aforementioned FAQ. In its comments, CMS states that this change within the PFS is solely to conform regulation with statute and maintain consistency across care settings. If the policies are to align, then those services that took place prior to October 1, 2025 would be considered established and not require the initial in-person visit, as seems clear from the explicit notation by CMS in its comments that the in-person requirements will be placed only on services taking place from October 1, 2025 and onwards. However, what remains less clear is what shall be considered the beginning date for the subsequent in-person visit every 12 months – does that time period also begin on October 1, 2025, or on the date that the patient first received services via telecommunications technology? CMS noted it will address the approach to these requirements for FQHCs/RHCs in future guidance, however as of the time this fact sheet is being written, CMS has not yet released additional guidance.

Center for Connected Health Policy

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