

Home-Based Medical Care: Telehealth Guidelines & Coding Requirements – 2026

Purpose

This resource is designed to provide guidance to home based medical care programs in the use of telehealth services to care for their patients with the expansion of reimbursement opportunities post pandemic. Refer to CMS guidelines¹ for full details and requirements.

Introduction

“Telehealth,” “telemedicine,” and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient’s health. The Centers for Medicare and Medicaid Services (CMS) has very specific coverage requirements for defining Medicare Telehealth Services². CMS continuously provides regulatory relief and increased opportunities for providers to use technology to care for patients, including video visits, telephone Evaluation & Management (E/M) services, virtual check-ins, remote evaluation of photos or videos, online digital E/M services or E-visits, and remote patient monitoring services.

Prior to the pandemic, Medicare would cover telehealth services for only patients located in a county outside of a metropolitan statistical area (MSA) or rural healthcare professional shortage area (HPSA). At the time CMS required the patient to travel to an approved healthcare facility, referred to as an “originating site” to receive telehealth services from a distant site (the location of the provider at the time of the encounter) provider.

With the implementation of PHE, providers were able to protect the public and continue medical care for their patients under the Coronavirus Preparedness and Response Supplemental Appropriations Act and other legislative actions signed into law. As a result of the pandemic, CMS eliminated the originating and distant site requirements temporarily, and began reimbursing telehealth services at the same rate as in-person care.

Since the ending of the PHE in May 2023, CMS has extended coverage and payment for telehealth services until January 30, 2026, with temporary and permanent changes to specific guidelines and billing codes as well as implementation of new guidelines and billing codes.

Temporary Changes implemented until January 31, 2026

- Medicare patients can receive telehealth services in their home
- There are no geographic restrictions for originating site for non-behavioral/mental telehealth services
- Some non-behavioral/mental telehealth services can be delivered using audio-only communication platforms
- An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required
- Telehealth services can be provided by all eligible Medicare providers

¹ <https://www.cms.gov/medicare/health-plans/medicareadvtspecratestats/risk-adjustors-items/cpt-hcpcs>

² <https://www.cms.gov/medicare/coverage/telehealth/list-service>

Permanent Changes implemented for rendering telehealth services

- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can serve as a distant site provider for behavioral/mental telehealth services
- Medicare patients can receive telehealth services for behavioral/mental health care in their home
- There are no geographic restrictions for originating site for behavioral/mental telehealth services
- Behavioral/mental telehealth services can be delivered using audio-only communication platforms
- Rural Emergency Hospitals (REHs) are eligible originating sites for telehealth

Eligible Distant Site Practitioners:

Starting on January 1, 2024, Mental Health Counselors (MHCs) and Marriage Family Therapists (MFTs) have been added as distant site practitioners for purposes of providing telehealth services. An inclusive list of eligible providers who can provide and bill for telehealth services, subject to scope of practice laws, are as follows:

- Physicians
- Nurse Midwives
- Licensed Clinical Social Workers
- Registered Dietitians
- Occupational Therapists
- Physician Assistants
- Certified Nurse Anesthetists
- Mental Health Counselors
- Nutrition Professionals
- Speech-language Pathologists
- Nurse Practitioners
- Clinical Psychologists
- Marriage Family Therapists
- Physical Therapists
- Audiologists

Billing Telehealth

Place of Services Codes

When submitting claims for reimbursement of rendered telehealth services, it is important to choose the correct place of service to prevent delayed or denied claims. As of January 1, 2024 the following Place of Service codes will be enforced when billing telehealth services:

- **POS 02:** Telehealth provided other than in patient's home. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
- **POS 10:** Telehealth provided in patient's home. Patient is located 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.

Modifiers

- **95** -- Payors may require the 95 modifier to claims that are submitted for telehealth, interactive audio-visual services rendered; this is payor specific. Medicare does not require the 95 modifier for outpatient Physician and NPPP visits.
- **93** -- 2-way, interactive, audio-only

Consent

Per CMS, a patient's consent is required for all services, including non-face-to-face services. A provider may get the patient's consent at the same time the provider is rendering services. Direct supervision is not required to get consent. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for the services provided. The person getting consent can be an employee, independent contractor, or leased employee of the billing practitioner.

Virtual Care Options and Reimbursement Opportunities

Video Visits

- If a telehealth visit is conducted using a two-way audio and video telecommunication method, permitting real-time communication between the provider and the patient, you can report the service using the home E/M (CPT 99341-99345 and CPT 99347-99350). Report the Place of Service (POS) 10: *patient at home*

Non-Physician Practitioners

Other qualified health care professionals, including licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists, eligible to bill for telehealth services can report Telephone E/M services using the following codes:

- CPT 98966 Telephone E/M 5-10 minutes; Non-Physician Practitioner; 2026 CMS National Non-Facility Payment \$11.70
- CPT 98967 Telephone E/M 11-20 minutes; Non-Physician Practitioner; 2026 CMS National Non-Facility Payment \$21.40
- CPT 98968 Telephone E/M 21-30 minutes; Non-Physician Practitioner; 2026 CMS National Non-Facility Payment \$29.67

CPT codes 98966-98968 have been added as permanent codes on Medicare's list of telehealth services: providers should report the POS where the service was rendered without any modifier.

Other Audio Only Services

CMS will also pay for a variety of counseling, education, psychotherapy, and nutrition and therapy services using audio-only technology. Below is a list of services pertinent to home-based care but please refer to [Medicare's List of Telehealth Services](#)³.

- Advance Care Planning (ACP) CPT 99497 (minimum of 16 minutes) and CPT 99498 (minimum of 46 minutes, billed in conjunction with 99497). ACP requires a medical discussion by a qualified provider discussing end-of-life preferences or advance directives with the patient and/or caregiver
- Annual Wellness Visits (HCPCS G0438, G0439)
- Smoking Cessation Services (CPT 99406, 99407)
- Alcohol and/or substance abuse (other than tobacco) structured assessment (e.g., AUDIT*, DAST**), and brief intervention services (HCPCS G0396, G0397)
- Annual Alcohol Misuse Screening and Counseling (HCPCS G0442, G0443)
- Chronic Care Management (CCM) Care Planning Services (HCPCS G0506); please note this service is only to be used one time for new patients or patients who are not seen within a year when first enrolled in CCM

*Alcohol Use Identification Test

**Drug Abuse Screening Test

Additional Implementation Considerations

Physical Exams

Physical Examination via telehealth is limited, but it is permissible/possible for a provider to document pertinent observations such as skin color, skin lesions/rashes, quality of respiration and evidence of wheezing or dyspnea, and vital signs as reported by the patient. When this is done, these factors may also contribute to the level of coding.

Documentation Requirements

Providers should document telehealth services in the same way they would document a face-to-face service. E&M coding requires a medically appropriate history and/or examination.

³ <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

Technology

Most Medicare telehealth services require interactive audio and video telecommunications permitting real-time communication between the provider and the patient at home. 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. In this case, append modifier 93 to the CPT code.

Communication Technology-Based Services (CTBS)

During the PHE, clinicians could provide remote evaluation of patient video/images and virtual check-in services using one of the HCPCS codes: G2010-98016 Note that these services are not considered "telehealth" per CMS.

Healthcare providers should report the telephone E/M CPT codes as they offer higher reimbursement than virtual check in services.

Virtual Check-in (CPT 98016)

- Includes a minimum 5-10-minute medical discussion by a physician or other qualified healthcare professional with the patient/caregiver; this cannot include clinical staff time
- Communication may be audio-only (e.g., telephone) or two-way video
- Can be provided **ONLY** established patients
- Intended to assess the patient's condition to determine if a face-to-face (F2F) visit is needed
- Cannot be related to an E/M F2F (or telehealth visit) visit within the previous 7 days and cannot result in an E/M or telehealth visit within the following 24 hours or the next available appointment
- Requires a patient-initiated question or call
- Verbal patient consent is required; however, as a result of the Medicare 2026 Physician Fee Schedule Final Rule, only a once-per-year annual consent is required for CTBS services as long as the patient is made aware of possible cost-sharing, 2026 CMS National Non-Facility Rate \$17.46; wRVU 0.30

Virtual Check-in (HCPCS G2252)

- Includes a minimum 11–20-minute medical discussion by a physician or other qualified healthcare professional with the patient/caregiver; this cannot include clinical staff time
- Communication may be audio-only (e.g., telephone) or two-way video
- **ONLY** established patients
- Intended to assess the patient's condition to determine if a face-to-face (F2F) visit is needed
- Cannot be related to an E/M F2F (or telehealth visit) visit within the previous 7 days and cannot result in an E/M or telehealth visit within the following 24 hours or the next available appointment
- Requires a patient-initiated question or call
- Verbal patient consent is required; however, as a result of the Medicare 2026 Physician Fee Schedule Final Rule, only a once-per-year annual consent is required for CTBS services as long as the patient is made aware of possible cost-sharing
- 2026 CMS National Non-Facility Payment \$28.53; wRVU 0.50

Remote Evaluation of recorded video and/or image (photo) (HCPCS G2010)

- Pre-recorded image and/or video of sufficient quality provided by the patient or caregiver
- Requires documentation of consent at least once per year (may be verbal, written, or electronic)
- Requires interpretation and follow-up to the patient and/or caregiver within 24 business hours (follow-up may be via a patient portal communication, telephone, secure text/email or two-way video)
- Post-PHE can be provided **ONLY** established patients
- 2026 CMS National Payment Amount \$13.09; wRVU 0.18

Remote assessment of recorded video and/or image (photo) by a non-physician/QHP healthcare professional (HCPCS G2250)

- Reported by providers without E/M within their scope of practice including licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists
- Pre-recorded image and/or video of sufficient quality provided by the patient or caregiver
- Requires documentation of consent at least once per year (may be verbal, written, or electronic)
- Requires interpretation and follow-up to the patient and/or caregiver within 24 business hours (follow-up may be via a patient portal communication, telephone, secure text/email or two-way video)
- Can be provided ONLY established patients
- 2026 CMS National Payment Amount \$13.09; wRVU 0.18

Online Digital E/M Services or E-Visits

Digital communications that occur over a secure platform (e.g., secure email or digital applications) or patient portal over a 7-day period addressing an acute issue or symptom that does not require an in-person or telehealth visit. These services include the following:

- CPT 99421: Online digital E/M, established patient by a qualified provider (i.e., physician, nurse practitioner, physician assistant), cumulative 7 days, 5-10 minutes; 2026 CMS National Non-Facility Payment \$15.78; wRVU 0.25
- CPT 99422: Online digital E/M, established patient by a qualified provider (i.e., physician, nurse practitioner, physician assistant), cumulative 7 days, 11-20 minutes; 2026 CMS National Non-Facility Payment; \$30.88; wRVU 0.50
- CPT 99423: Online digital E/M, established patient by a qualified provider (i.e., physician, nurse practitioner, physician assistant), cumulative 7 days, 21 minutes or more; 2026 CMS National Non-Facility Payment \$49.01; wRVU 0.80
- CPT 98970: Online digital assessment and management, established patient, by a qualified non-physician healthcare professional (i.e., licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists) cumulative 7 days, 5-10 minutes; 2026 CMS National Non-Facility Payment \$12.42; wRVU 0.25
- CPT 98971: Online digital assessment and management, established patient, by a qualified non-physician healthcare professional (i.e., licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists), cumulative 7 days, 11-20 minutes, 2026 CMS National Non-Facility Payment \$23.16; wRVU 0.44
- CPT 98972: Online digital assessment and management, established patient, by a qualified non-physician healthcare professional (i.e., licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists), cumulative 7 days, 21 minutes or more, 2026 CMS National Non-Facility Payment \$34.57; wRVU 0.69
- Do not report E-visits for nonevaluative electronic communications such as reviewing test results or scheduling appointments.
- These are patient initiated communications that cannot be related to an E/M or previous reportable service for the same problem within the past 7 days. Do not report an E-visit if within the 7-day period a separately reportable service for the same problem occurs.
- The 7-day period begins when the provider personally reviews the patient generated issue and is cumulative over the next 7-days when the problem is addressed. Service time includes review of the initial inquiry, review of patient records or data related to the problem, personal interaction with clinical staff focused on the patient's problem, development of management plans, generation of prescriptions, ordering of tests, and subsequent communication with the patient through online telephone, email, or other digitally supported communications.
- All qualified healthcare professionals within the same group practice who are involved and contribute to the online digital assessment of the same problem contribute to the cumulative service time.
- May be reported for new and established patients.
- Remote Patient Monitoring Services CPT 99453, 99454, 99445, 99091, 99457, 99470 and 99458 (refer to separate HCCIntelligence™ Remote Patient Monitoring resource)



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The John A. Hartford Foundation

HCCIntelligence™ is funded in part by a grant from The John A. Hartford Foundation.

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