Medicare's Coverage of Telehealth Services – Frequently Asked Questions

1. What is telehealth?

Telehealth includes certain services that an individual receives from a health care provider outside of an in-person office visit. A telehealth service is a full visit with a provider using telephone or video technology that allows for both audio and video communication.

2. What types of services does Medicare cover as telehealth?

Medicare covers certain telehealth benefits. Some examples include:

- Lab test or x-ray result consultations
- Post-surgical follow-up
- Prescription management
- Preventive health screenings
- Urgent care issues like colds, coughs, and stomach aches
- Mental health treatment, including online therapy and counseling
- Treatment of recurring conditions, like migraines or urinary tract infections
- Treatment of skin conditions

Individuals can ask their doctor about telehealth options and whether it would be suitable for their individual circumstances.

3. Does Medicare cover virtual check-ins?

Yes. Original Medicare Part B covers virtual check-ins, also called "brief communication technology-based services" with certain providers. These check-ins allow individuals to communicate with their providers through audio and video communication technology or by sending in photo or video images for remote assessment. Their doctor or other provider can respond by phone (audio or video), secure text messaging, email, or use of a patient portal.

Virtual check-ins are for patients who have an established relationship with their provider, and the patient must verbally consent to receive these services. **A virtual check-in is not a full appointment,** and Medicare pays for the virtual check-in at a lower rate than an in-person or telehealth appointment. A covered check-in does not

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relate to a medical visit within the past seven days and does not lead to a medical visit within the next 24 hours (or the soonest appointment available). Virtual check-ins are covered at 80% of the Medicare-approved amount after an individual meets the Part B deductible, and the individual owes a 20% coinsurance.

4. How is a telehealth visit different from a virtual check-in?

Virtual check-ins are separate from Medicare's telehealth benefit. The virtual check-in is generally a brief (5-10 minute) discussion with a provider, as compared to a full telehealth visit, which is treated and reimbursed in the same way as an in-person visit. Medicare telehealth visits usually require real-time communication through audio and visual technology, while virtual check-ins can use a broader range of communication methods such as text messaging and email. Also, virtual check-ins are available to Medicare beneficiaries in all areas.

5. How did Medicare cover telehealth before the COVID-19 public health emergency?

To understand how Medicare's coverage of telehealth has changed during the COVID-19 public health emergency (PHE), first it is important to know the coverage rules that were in place **before** the PHE. This section does not reflect current PHE-related coverage flexibilities (see question 6) or possible future changes (see question 8).

Before the COVID-19 public health emergency, **Original Medicare Part B** covered telehealth in limited situations.

Locations

Outside of PHE-related flexibilities, Original Medicare beneficiaries could generally only access telehealth if they lived in a rural area and traveled from their home to a local medical facility to receive the services. They had to be at an "originating site" in an eligible geographic area, including rural health professional shortage areas (HPSA) and counties not classified as a metropolitan statistical area (MSA). Eligible originating sites included physician and practitioner offices; hospitals; critical access hospitals; rural health clinics; federally qualified health centers; hospital-based or critical access hospital-based renal dialysis centers (including satellites); skilled nursing facilities; and community mental health centers.

With these requirements, beneficiaries could not receive telehealth services in their own homes, and Original Medicare beneficiaries in urban areas were generally ineligible for

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telehealth. The originating site geographic limitations were only waived in circumstances where:

- Individuals required telehealth services to treat a diagnosed substance use disorder or co-occurring mental health disorder. These individuals had the option of accessing telehealth services from their home or from a medical facility.
- Individuals required telehealth services to diagnose, evaluate, or treat symptoms of acute stroke. These individuals had the option of accessing telehealth services from their home or from a medical facility.

Technology requirements
Original Medicare required that telehealth visits be conducted with interactive, two-way audio and video technology that allows for real-time communication between the practitioner and the beneficiary at the originating site. The only exception to this interactive telecommunications requirement was for federal telemedicine demonstration programs in Alaska and Hawaii, where beneficiaries could send medical information to a practitioner to review later without real-time interaction.

Practitioners
Original Medicare covered telehealth services provided by eligible practitioners, which included physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified nurse-midwives, certified registered nurse anesthetists, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.

Medicare Advantage (MA)
Medicare Advantage Plans must cover all of the telehealth benefits included in Original Medicare, but they may also cover additional telehealth benefits. MA Plans could offer benefits not covered by Original Medicare, such as telehealth visits provided in a beneficiary's home or telehealth services for individuals who live outside of a rural area.

6. How has coverage of telehealth changed during the COVID-19 public health emergency?

CMS and Congress have acted to expand coverage and access during the public health emergency.

Locations
Previously, only Medicare beneficiaries in rural areas could access telehealth, and they were required to travel to an authorized health care setting (see question 5). During the

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PHE, telehealth services are covered for all beneficiaries in any geographic area, and they can receive these services at home in addition to health care settings.

Technology requirements
Beneficiaries must generally still use an interactive audio and video system that allows for real-time communication with the provider. Guidance from the Department of Health and Human Services (HHS) allows providers to temporarily use any non-public facing remote technology (such as FaceTime, Zoom, or Skype) to communicate with their patients.

During the PHE, limited telehealth services can be delivered using audio only, via audio-only telephone or a smartphone without video. These services include counseling and therapy provided by an opioid treatment program, behavioral health care services, and patient evaluation and management.

Practitioners
Previously, Medicare only covered telehealth services provided by eligible practitioners (see question 5). During the PHE, any health care professional that is eligible to bill Medicare for professional services can provide and bill for telehealth services. This includes professionals who previously could not receive payment for Medicare telehealth services, such as physical therapists, occupational therapists, and speech language pathologists.

Services
Original Medicare has expanded the list of covered telehealth services during the PHE, including emergency department visits, physical and occupational therapy, and certain other services. For example, a doctor can use telehealth in place of the face-to-face visits required to prescribe Medicare-covered home health care. If a beneficiary has questions about what services they can receive via telehealth, they should ask their doctor.

Medicare Advantage
In response to the PHE, CMS has provided flexibility for Medicare Advantage Plans to expand coverage and reduce or waive cost-sharing for telehealth services.

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7. What costs do Medicare beneficiaries pay for telehealth services?

Original Medicare covers telehealth services under Part B. After beneficiaries meet the Part B deductible ($233 in 2022), they pay 20% of the Medicare-approved amount for the service from providers who accept Medicare assignment. Medicare Advantage beneficiaries should contact their plan to learn about their telehealth costs.

Cost-sharing for telehealth has not changed during the COVID-19 public health emergency. However, providers can choose to reduce or waive cost-sharing for telehealth visits. Providers usually cannot routinely waive cost-sharing, but the Department of Health and Human Services (HHS) Office of Inspector General has provided this flexibility during the PHE.

8. Will the expanded coverage of telehealth end after the COVID-19 public health emergency expires?

Certain flexibilities for Medicare, including expanded coverage of telehealth services, have been in place since 2020 as a result of the PHE. Congress passed legislation in March 2022 that extends telehealth flexibilities for 151 days beginning on the first day after the end of the PHE. As of April 16, 2022, the PHE declaration has been extended until mid-July. CMS should evaluate all of the PHE-related flexibilities to determine whether some should be retained as rule changes long-term.

9. Do beneficiaries need to be on the lookout for potential fraud related to telehealth?

Yes. With the expansion of telehealth services, beneficiaries should be aware of people using telehealth for fraudulent purposes. The following scenarios are examples of potential telehealth fraud:

Scenario	Potential fraud
A beneficiary is contacted by a provider they do not know or have not met before to set up a telehealth appointment. The caller offers cash payments or free prescription drugs to get their personal information.	The caller will likely start billing Medicare for items and services the beneficiary does not need or does not receive, like lab tests, braces, or orthotics.

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A beneficiary receives an unsolicited phone call from someone wanting to verify their pain symptoms.	The caller is likely a telehealth doctor trying to approve the beneficiary for durable medical equipment (DME) that they do not need or did not request.
A beneficiary receives an unsolicited phone call from someone wanting to verify their family history of cancer.	The caller is likely a telehealth doctor trying to approve the beneficiary for a genetic testing kit that actually needs to be ordered by their treating physician.

If an individual suspects fraud, they should call 1-800-MEDICARE. They can report potential telehealth fraud, errors, or abuse to their local Senior Medicare Patrol.

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