Reimbursement Tips:
Medicare Extended FQHC Telehealth Services

Overview

Eligible Medicare Part B telehealth visits are reimbursable when they involve the use of interactive audio-visual or audio-only telecommunications technology permitting two-way, real-time communication between the qualified provider and patient. Any of these services may also be furnished in-person.

Flexibilities provided during the COVID-19 Public Health Emergency, and extended through the Consolidated Appropriations Acts of 2023, allow eligible FQHC practitioners to deliver qualified Medicare Telehealth Services as a distant site. This flexibility was extended until January 1, 2026.

Visits via telecommunications technology became permanent for qualifying mental health services on January 1, 2022. For information related to these services please see Mental Health Telecommunication Services Reimbursement Tips. Also see NACHC resource: *Medicare Billing Lingo, Defined!* for definitions of terms used throughout this document.

While the requirements for delivering telehealth services to Medicare beneficiaries are the same across the country, there is variability among the states with regard to telehealth for Medicaid beneficiaries. Additionally, private payors may also have differences in their telehealth service policies.

Eligible Patients

- Medicare Part B beneficiaries
- New or established patient
- Provide consent for services furnished via telehealth
- May be located in their home, including temporary housing such as hotels, homeless shelters, or places the patient may need to go for reliable internet services or privacy within a short distance from the actual home (i.e., neighbor's home, a car parked close by, or a nearby community space)
- May opt to receive services in-person at any time

Note: A home does not include a hospital, skilled nursing facilities or similar facilities where the patient may reside temporarily or permanently for care.

Authorized Billing Providers

Who they are:

- Physicians (MD,DO)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Certified Nurse Midwives (CNM)

What they do:

- ✔ Obtain patient consent (verbal or written) before or at the time of service. If not obtained by billing provider, consent may also be obtained by auxiliary personnel under general supervision (See Medicare Billing Lingo, Defined! for definitions).
- ✔ Personally furnish services which require FQHC practitioner licensure, scope of practice, education and training. (i.e., Evaluation and Management (E/M) services) at the federal and/or state level.
- ✔ Provide telehealth services while located in the health center or even in their home (working on behalf of the health center).

Reimbursement Tips: Medicare Extended FQHC Telehealth Services

- ✔ Provide direct supervision of those auxiliary personnel eligible to furnish part or all of allowable telehealth service.
- ✔ Provide direct supervision of face-to-face and non-face-to-face services performed by qualified nursing or auxiliary personnel.
- ✔ Utilize HIPAA compliant telecommunications technology with both audio and video capabilities.
- ✔ Comply with any cross state licensure may be required in order to deliver telehealth services across state lines and for patients to receive telehealth services from a provider in a different state. These rules may vary depending upon the type of service being furnished (i.e., behavioral health vs. medical).

  Note: Services, whether face-to-face or non-face-to-face, that do not require personal performance by an FQHC practitioner (e.g., non-E/M services) may be provided by qualified nursing or auxiliary personnel under the billing practitioner's supervision—either in-person or, until January 1, 2026, via appropriate virtual audio-visual (excluding audio-only) technology.

Auxiliary Personnel

Who they are (examples):

- Nurses (Clinical Nurse Specialist (CNS), Registered Nurse (RN), Licensed Practical Nurse (LPN)
- Medical Assistants
- Registered Dieticians or Nutrition Professionals for DSMT and MNT services. See NACHC Reimbursement Tips: Diabetes Self-Management Training/Medical Nutrition Therapy

What they may do:

- ✔ Obtain patient consent for services (verbal or written) under general supervision as part of the telehealth flexibility. When this flexibility ends on January 1, 2026, and services revert back to being in-person, the authorized billing provider is required to obtain patient consent.
- ✔ Furnish eligible services within their scope of practice and state requirements, and whom the billing practitioner authorizes and deems qualified to perform a service under his/her direct supervision. Services (i.e. E/M services) that must be personally performed by the practitioner may not be furnished by auxiliary personnel.

Services Elements, Coding & Billing

CODE	*Service Elements*	*Service Provider*	*FQHC Medicare Billing Code & Rate*
G2025	Telehealth distance site services furnished by a FQHC only. FQHCs are eligible to furnish those Medicare Telehealth Services which are typical FQHC services	FQHC practitioners Auxiliary personnel eligible to furnish certain services via direct supervision of the FQHC practitioner.	G2025: $94.45 Modifier 95 for audio-visual telehealth or Modifier FQ for audio-only telehealth is required to be appended to G2025. FQHCs are not required to report the CPT service code on the claim; however, the medical record should specify the services rendered.

The reimbursement rate is based on the 2025 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI. Code descriptions taken from the AAPC's HCPCS Level II 2025 Manual.

Reimbursement Tips: Medicare Extended FQHC Telehealth Services

Modifier 95 is a CPT® code modifier used to identify a "synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system."

Effective January 1, 2025, CMS permanently updated the definition of an "interactive telecommunication system" to include two-way, real-time audio-only communication for telehealth visits. Audio-only services are permitted only when:

1. The patient is in their home, and
2. The distant site physician or practitioner has the capability to use real-time audio and video equipment, and
3. The patient either cannot use or declines to use video technology.

The practitioner must use clinical judgment to determine if audio-only technology is sufficient for the Medicare telehealth service. No additional documentation is required beyond the appropriate modifier: FQ for FQHCs. Some Medicare Administrative Contractors (MACs) may also require modifier 93.

The AMA has deleted CPT codes 99441-99442 for audio-only Evaluation and Management (E/M) services and introduced new codes for telehealth E/M services: **98000-98007** for audio-visual services and **98008-98015** for audio-only services, applicable to new or established patients. However, CMS did not adopt these new codes. Instead, audio-only services are included under the updated definition of an interactive telecommunication system and apply to E/M services listed on the Medicare Approved Telehealth List.

For services included in the CMS approved telehealth list where cost-share is waived, Medicare will adjust the coinsurance and payment calculation to reflect the Physician Fee Schedule (PFS) methodology. This means that the coinsurance is 20% of the lesser of the allowed amount ($94.45) or actual charges, and the payment itself is 80% of the lesser of the allowed amount or actual charges.

It is important that FQHCs check with each payer for the coding and billing requirements. FQHCs are also urged to check with local MAC(s) to mutually understand expectations regarding claim format, use of modifiers, and other nuances related to reimbursement.

Beyond the distant site telehealth flexibilities, FQHCs can be originating sites for telehealth if they are in located in a certain geographic locations. Medicare originating site coding and billing policy differs from distant site telehealth policy, and FQHCs must adhere to those requirements.

Documentation

Be sure to capture the following documentation elements when billing for telehealth services:

- ✔ Patient consent, who obtained it, and the mode under which it was obtained
- ✔ Services furnished, which follows the same documentation practice in place for face-to-face visits
- ✔ The date and practitioner who furnished the services
- ✔ The locations of both the provider and patient
- ✔ Clinical participants
- ✔ The modality of the telecommunications technology

The Department of Health and Human Services (HHS) provides the most current HIPAA telehealth policy resources.

The billing practitioner is ultimately responsible for documentation, including that of any contracted auxiliary staff who furnish services under the clinical care and treatment of this same billing practitioner.

References

- AMA. 2025 CPT Codebook
- AAPC. 2025 HCPCS Level II Codebook
- CMS CY 2022 Physician Fee Schedule Final Rule https://www.federalregister.gov/documents/2021/11/19/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part
- CMS. CY 2023 Physician Fee Schedule Final Rule govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf
- CMS. CY 2025 Physician Fee Schedule Final Rule https://www.federalregister.gov/public-inspection/2024-25382/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule
- CMS. Medicare Telehealth Services List. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- Consolidated Appropriations Act, 2023. https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf
- New & Expanded Flexibilities for RHCs & FQHCs SE20016 - New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers

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