Frequently Asked Questions (FAQ)

Executive Summary:

Federal legislation and regulatory activity since 2021 have involved changes to Medicare Fee for Service (FFS) and Medicare Advantage (MA) plan coverage rules, including telehealth mental health (MH) requirements and extension of public health emergency flexibilities. These changes aim to increase access to MH services and ensure continuity of care through telehealth, while also maintaining certain in-person visit requirements to ensure appropriate care is being delivered. Kaiser Permanente (KP) MH and quality market leaders have raised questions concerning Medicare MH telehealth coverage rules, including in-person visit requirements, and seek guidance to compliance.

Medicare mental health telehealth expansion timeline: The 2021-2023 Consolidated Appropriations Acts extended Medicare coverage for mental health telehealth, allowing audio-only visits with a required in-person visit within six months, with extensions delaying this requirement to September 30, 2025.

Medicare Advantage plan compliance: Medicare Advantage Plans must provide benefits consistent with Traditional Fee-for-Service Medicare coverage and payment rules, including for telehealth services.

Substance use disorder services: Telehealth requirements for the treatment for substance use disorder and co-occurring mental health and substance use disorder are addressed separately and do not include an in-person visit requirement.

In-person visit timing requirements for mental health services: An initial in-person visit without telehealth must occur within six months before the first telehealth mental health service, followed by in-person visits at least every 12 months during ongoing treatment.

Exceptions to mental health in-person visits: No exceptions exist for the initial in-person visit unless the patient began telehealth treatment during the public health emergency or its extensions, in which case only annual in-person visits are required. Follow-up in-person visits may be waived if risks outweigh benefits or if another same-specialty provider in the group conducts the visit.

Documentation for exceptions: Providers must document clear justification in medical records when foregoing the 12-month in-person visit, including patient agreement on risks and burdens outweighing benefits.

Cross-department and provider reliance: Providers may rely on in-person visits conducted by other providers within the same specialty, subspecialty, and group, even across departments, if the telehealth provider is unavailable. Collaborative Care Managers and unlicensed trainees may also rely on supervising providers' in-person visits due to incident-to billing provisions.

Revised October 1, 2025

Applicability to staff and treatment types: In-person visit requirements apply only to qualified practitioners billing Medicare independently, excluding ancillary or peer support staff, and cover all treatment modalities including group therapy.

Urgent and crisis services: No specific exceptions exist for in-person visit requirements for urgent or crisis mental health services provided via telehealth, which remain payable under Medicare.

Oversight responsibilities: Medicare Advantage organizations must monitor and ensure compliance with in-person visit requirements through internal and external audits and maintain accountability for delegated entities.

Supervision and telehealth service delivery: Licensed mental health providers can deliver services under general supervision, while unlicensed trainees require direct supervision, which may be provided via real-time audiovisual technology until December 31, 2025, with proposals to make this permanent excluding audio-only supervision.

Table of Contents

Background

The 2021, 2022, and 2023 Consolidated Appropriations Acts (CAA) each addressed coverage for Medicare MH telehealth services furnished by eligible Medicare providers. In 2021, the CAA expanded Medicare coverage for telehealth services for the purpose of diagnosis, evaluation, or treatment of MH disorders after the end of the COVID-19 PHE, allowing the use of audio-only visits for MH services with the condition that an in-person visit is completed within six months.[1] In 2022, the CAA extended MH telehealth coverage, including audio-only services 151 days post the end of the Covid-19 PHE.[2] The 2023 CAA provided a 2-year extension of the telehealth Covid-19 PHE allowances (including audio-only) and delayed the in-person visit requirement to December 31, 2024.[3] The Continuing Appropriations and Extensions Act, 2025 further extended the telehealth coverage, delaying the in-person visit requirement effective date through September 30, 2025.

However, "starting October 1, 2025, the statutory limitations that were in place for Medicare telehealth services before the COVID-19 PHE will retake effect for most telehealth services. These include:

- Geographic restrictions
- Location restrictions on where you can provide services
- Limitations on the scope of practitioners who can provide telehealth services."[4]

While all master's licensed practitioners may now independently provide and bill for services to Medicare members or provide services under incident to general supervision provisions[5], telehealth flexibilities implemented during and since the Covid-19 public health emergency (PHE) will end on September 30, 2025.

Additionally, MA plans were notified they are required to provide the Traditional FFS Medicare benefit and follow the same coverage rules.[6] In 2023, CMS reaffirmed its coverage policy and codified the expectation that MA plans follow payment as well as coverage rules, CMS explained that MA plans are expected to adhere to Traditional FFS Medicare coverage and payment criteria, and that the only flexibility to deviate from Traditional FFS Medicare criteria is in the form of supplemental benefits. In the 2024 Medicare Advantage final rule, CMS explained,

> "Traditional Medicare pays for a service only when certain conditions are met, meaning that those certain conditions must be met for the service to be

[1] 2021 EXPANDING ACCESS TO MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH
[2] 2022 CAA, Sec. 301 REMOVING GEOGRAPHIC REQUIREMENTS AND EXPANDING ORIGINATING SITES FOR TELEHEALTH SERVICES.
[3] 2023 CAA, Sec. 4121 COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.
[4] MLN901705 - Telehealth & Remote Patient Monitoring
[5] 42 CFR § 410.26 Services and supplies incident to a physician's professional services: Conditions.
[6] 42 CFR § 422.135(b) Additional Telehealth Benefits_General Rule

considered a Traditional Medicare basic benefit, these same conditions, including setting, must be met in order for the service to be considered part of the basic benefit of an MA plan."[7]

Q1. When do the Medicare in-person visit requirements take effect?

Without further federal legislation or regulatory intervention, the in-person visit requirements will take effect October 1, 2025. Existing flexibility which allows telehealth without a prior in-person visit expires on September 30, 2025.[8]

Q2. What are the in-person visit time requirements for Medicare mental health telehealth visits?

An in-person visit is defined in the rule to mean, "without the use of telehealth."[9] The Medicare mental health telehealth rules require an in-person visit within 6 months prior to the initial telehealth visit, as well as subsequent in-person visits at least every 12 months while treatment continues.

Q3. Do the in-person mental health visit requirements apply to addiction/substance use disorder (SUD) telehealth treatment services?

No. The Medicare in-person MH telehealth visits requirements apply only to MH visits, excluding substance use disorder (SUD) and those the individual provider is treating for co-occurring SUD and MH conditions. While Medicare rules covering MH generally include SUD, there is specific statutory language exempting the in-person requirements for telehealth for individuals with an SUD diagnosis "for the purposes of treatment of such disorder or co-occurring mental health disorder."[10]

Q4. Are there exceptions to the in-person visit requirement and do they apply for initial and follow-up visits?

There are no exceptions to the in-person visit required within 6 months prior to the initial telehealth visit, other than they do not apply to someone already in treatment via telehealth before the extended flexibilities end on September 30, 2025. In the 2023 PFS Final Rule, CMS clarified that a beneficiary who began receiving mental health services via telehealth during the public health emergency (PHE) or the extended flexibilities that followed are considered established and, "they would not be required to have at least one in-person visit within 6 months."[11] CMS further emphasized in this rule that instead, these beneficiaries will be, "required to have at least one in-person visit every 12 months (so long as any such telehealth service is furnished by the same sub-specialty in the same practice)."

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[7] Medicare Program; Contract Year 2024 Final Rule, 88 Fed. Reg. 22120, 22192 (April 12, 2023).
[8] MLN1986542 – Medicare & Mental Health Coverage
[9] 42 CFR 410.78(b)(3)(xiv)(A)
[10] 42 USC 1395m(m)(7); *see also* 42 CFR 410.78(b)(3)(xii).
[11] Calendar Year (CY) 2023 Centers for Medicare and Medicaid (CMS) Physician Fee Schedule final rule - Section Implementation of Telehealth Provisions

There are, however, two exceptions to the in-person follow-up visit within 12 months requirements for subsequent telehealth treatment visits:

1) The physician or practitioner has furnished an item or service in-person, without the use of telehealth, at least once within 12 months of each subsequent telehealth service described in this paragraph, **unless,** for a particular 12-month period, the physician or practitioner and patient agree that the risks and burdens associated with an in-person service outweigh the benefits associated with furnishing the in-person item or service.[12]
2) The requirements of paragraphs (b)(3)(xiv)(A) and (B) may be met by another physician or practitioner of the same specialty and subspecialty in the same group as the physician or practitioner who furnishes the telehealth service, if the physician or practitioner who furnishes the telehealth service described under this paragraph is not available.[13]

Q5. What are the documentation requirements for exceptions to the 12-month in-person visit requirements?

The practitioner must document clear justification in the patient's medical record the reason(s) for the decision to continue with telehealth without meeting the 12-month in-person visit, specifically the decision involving agreement with patient regarding the risks and burdens outweighing the benefits.[14]

Note also that while proposing changes to the Telehealth Services List and Review Process in the CY 2026 Physician Fee Schedule (PFS) Proposed Rule, CMS asserted individual practitioners should determine the modality of service considering the entirety of circumstances, including clinical profile and needs of the beneficiary. They state further that, "the physician or practitioner should use his or her complex professional judgment to determine the appropriate service modality on a case-by-case basis. As technology advances and more services may be safely furnished via telehealth and paid under the PFS, it is increasingly important for physicians and practitioners to exercise their professional judgment in determining the generally appropriate service modality for their patients to receive a service."[15] Documented justification to forego the otherwise required in-person visit can reasonably be expected to demonstrate such judgment.

Q6. Can a provider in one department rely on the in-person visit of a provider in another department?

Per the exceptions noted above in Q4, a provider in one department may rely on the in-person visit by a physician or practitioner in another when they are "of the same specialty **and** subspecialty in the same group" **and** the physician or practitioner who furnishes the telehealth is not available.

[12] 42 CFR 410.78(b)(3)(xiv)(B)
[13] 42 CFR 410.78(b)(3)(xiv)(C)
[14] 42 CFR 410.78(b)(3)(xiv)(B)
[15] Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee (pg. 109)

Q7. Can one provider type rely on the in-person visit of another provider type in the same department?

Only when the provider is of the same specialty **and** subspecialty, **and** in the same group as the physician or practitioner who furnishes the telehealth service, and the physician or practitioner who furnishes the telehealth service is not available.

Q8. If a Behavioral Health (BH) provider is in another department, such as primary care or emergency services, can a BH provider located in BH specialty services rely on the BH providers from the other departments in-person visit?

Yes, when the physician or practitioner is of the same specialty and subspecialty, in the same group, and the physician or practitioner who furnishes the telehealth service is not available.

Q9. What does it mean for the practitioner to be in the same specialty/subspecialty?

All physician and non-physician practitioners must be enrolled with Medicare to furnish services to Medicare members. Practitioner specialty codes describe the specific/unique types of medicine that physicians and non-physicians' practice. [16] For instance, psychiatrists, clinical psychologists, marriage and family therapists, licensed professional counselors, and licensed clinical social workers are all considered separate specialties. Additionally, psychiatry has sub-specialties delineating psychiatry, geropsychiatry, and neuropsychiatry. In the 2022 Physician Fee Schedule (PFS) Final Rule, CMS allowed, "a clinician's colleague in the same subspecialty in the same group to furnish the in-person, non-telehealth service to the beneficiary if the original practitioner is unavailable."[17]

Q10. May a Collaborative Care Manager rely upon the in-person visit of the primary care physician?

Yes, the Collaborative Care Manager may rely upon the supervising primary care practitioners in-person visits because they provide services incident to the billing provider.[18]

Q11. May an unlicensed associate trainee working in specialty BH rely upon the in-person visit of the physician (e.g., psychiatrist) or other qualified practitioner?

Yes, like with the Collaborative Care Manager above in Q8, the unlicensed associate trainee may rely upon the supervising physician or qualified practitioners in-person visit because they are providing services incident to the billing provider.

The difference is the Collaborative Care Manager may provide services under general supervision within the collaborative care management model (CoCM) but the unlicensed associate may only provide services to Medicare members under direct supervision of the supervising practitioner in specialty behavioral health (see Q14 about telehealth and incident to supervision).

[16] Medicare Claims Processing Manual - Chapter 26 - 10.8
[17] CY 2022 Payment Policies under the Physician Fee Schedule Pg 167
[18] MLN Booklet_BH Integration Services

Q12. Do the Medicare in-person visit requirements apply to ancillary and adjunctive support staff, including nursing, case management, and peer recovery services?

No. Per the CMS CY 2025 Telehealth FAQ, the Medicare telehealth requirements apply to qualified practitioners authorized to independently bill Medicare for their professional mental health services.[19] Ancillary, adjunctive, and peer support staff are not authorized independent practitioners.

Q13. Do the in-person visit requirements apply to all types of ambulatory treatment, including group therapy?

The in-person MH visit requirements apply to all qualified practitioners regardless of treatment modality. While group treatment is covered, including through telehealth, there's no exception provided for the in-person requirement.

Q14. Are there exceptions to in-person visit requirements for urgent and crisis services?

There's no explicit exception to the in-person telehealth rules when scheduling urgent or crisis services. Medicare pays for psychotherapy for crisis. These services may be provided to Medicare members via Telehealth when all applicable requirements are met.[20]

Q15. What are Kaiser Permanente's obligations to provide oversight of the contracted provider network in-person visit requirements?

Per CMS regulations, contracts between CMS and MA plans must include, "establishment and implementation of an effective system for monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the MA organization, including first tier entities; compliance with CMS requirements and the overall effectiveness of the compliance program."[21]

Additionally, as a condition of their contracts with CMS, MA Organizations (MAO) agree that they oversee and are accountable to CMS for all functions and responsibilities required by Medicare regulations. These obligations extend to the MAO's relationships with first tier, downstream and related entities that perform services on the MAO's behalf. Contracts between plans and such entities must "specify that the performance of the parties is monitored by the MA organization on an ongoing basis."[22]

This oversight is also underscored in sub regulatory guidance: "If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to other parties, written arrangements must specify that the performance of the parties is monitored by the MA organization on an ongoing basis, and either provide for revocation of the delegated activities or

[19] Telehealth FAQ Calendar Year 2025_Q2
[20] CMS Psychotherapy for Crisis
[21] CMS MA Organization General Provisisions_Conditions necessary to contract_§ 422.503(b)(4)(vi)(F)
[22] 42 CFR 422.504(i)(4)(iii)_Contract Provisions_MA organization relationship with first tier, downstream, and related entities

specify other remedies where CMS or the MA organization determines such parties have not performed satisfactorily."[23]

Q16. Will services provided to Medicare members under direct supervision have to be in-person when the applicable incident to supervision flexibilities end on December 31, 2025?

Medicare covers services provided by eligible professional practitioners licensed by the state in which they provide services, and auxiliary personnel under explicitly defined supervision requirements.[24] The 2023 PFS final rule expanded the list of qualified practitioners that can provide covered MH services to Medicare beneficiaries and changed the incident to supervision standard from direct to general for licensed MH providers.[25] The change to general supervision, allowed under Medicare incident to provisions, applies to licensed clinicians providing behavioral health (BH) services (where this may be considered), while direct supervision remains a possibility for unlicensed associate trainees who meet auxiliary personnel definitions. The 2025 PFS Final Rule extended the definition of direct supervision allowing it through real-time audio-visual interactive communications until December 31, 2025, for most services.[26]

However, the 2026 PFS Proposed rule is proposing to make this definition change permanent. As noted in the CMS Fact Sheet published on July 14, 2025, " We are also proposing, for services that are required to be performed under the direct supervision of a physician or other supervising practitioner, to permanently adopt a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only)."[27]

The comment period for the proposed 2026 rule ends on September 12th. *Any comments from KP will be coordinated and submitted by KP Government Relations.*

[23] Medicare Managed Care Manual, CMS Pub. 100-16, ch. 11, § 110.3
[24] CMS MLN Booklet_Medicare & Mental Health Coverage July 2024 (pg. 23)
[25] 2023 Physician Fee Schedule Final Rule_Revisions to the "Incident to" Physicians' Services Regulations for Behavioral Health Services
[26] CY 2025 Payment Policies Under the Physician Fee Schedule Final Rule_Direct Supervision Via Use of Two-Way Audio/Video Communications Technology
[27] Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule (CMS-1832-P) | CMS_Telehealth Services under the PFS