Medicare telehealth information

Effective Feb. 3, 2026

On Feb. 3, 2026, President Donald Trump signed a federal funding bill that extends key telehealth provisions initially implemented during the COVID-19 pandemic through Dec. 31, 2027. These provisions apply retroactively to Jan. 30, 2026. The legislation includes extensions to the Medicare telehealth flexibilities, which include:

- The expanded definition of originating sites
- The expanded list of clinician types that are able to provide telehealth care
- The inclusion of telehealth services furnished by federally qualified and rural health centers
- The waiving of specific in-person requirements for types of mental healthcare
- The allowance of audio-only modalities

Additional telehealth services

In addition to what is covered under the Original Medicare telehealth program and the extended flexibilities, CarePlus Health Plans® Medicare Advantage (MA) plans include in-network coverage of telehealth services through our "additional telehealth services" benefit (ATB). The ATB is separate from the Original Medicare telehealth flexibilities. The types of services included in the ATB are listed in members' Evidence of Coverage each year. In 2026, this includes telehealth services by primary care providers and specialists and individual sessions for mental health specialty services and psychiatric services. Out-of-network providers cannot provide services under the CarePlus ATB. Please refer to the CarePlus Claims Payment Policy, Telehealth and Other Virtual Services, at Member Resources | CarePlus Health Plans for more information.

FAQ

Telehealth audio-only risk adjustment

Q: The Centers for Medicare & Medicaid Services (CMS) will pay for certain Medicare services conducted by phone. Are these audio-only services acceptable for Medicare risk adjustment (MRA) purposes?

A: No. Based on the CMS April 10, 2020, health plan management system (HPMS) memo and updates made on Jan. 15, 2021, and May 4, 2022, services that qualify for risk adjustment must be performed using interactive audio telecommunication simultaneously with video telecommunication to permit real-time interactive communication.

Billing audio-only visits

Q: How should physician and healthcare professionals bill services that CMS has covered when provided as audio only?

A: CarePlus requests that providers bill audio-only services using Current Procedural Terminology (CPT®) codes 99202–99215 and the modifier "93" to identify services as being audio only and therefore not eligible for MRA. Billing the CPT code with the modifier "93" will clearly indicate that the service was provided as audio only. If providers have previously submitted audio-only visits without this configuration, CarePlus requests providers to correct those instances by submitting a corrected claim so they are appropriately identified as audio-only services via modifier "93."

Note: When a diagnosis code must be removed from a previously submitted MA claim, an additional process should be followed. Please send an inquiry to the MRADeleteRequests@humana.com mailbox for more information on the diagnosis code deletion process.

Billing audio and video visits

Q: How should physician and healthcare professionals bill services CMS has covered when provided as real-time, interactive audio and video?

A: For synchronous telemedicine services rendered via real-time, interactive audio and video telecommunication systems for 2026 dates of service, the claim should reflect the telehealth place of service (POS). There are two code options to indicate the POS when a service provided via telehealth is submitted: 1) POS 02 for telehealth services provided other than in the patient's home, or 2) new POS 10 for telehealth services provided in the patient's home, which is a location other than a hospital or other facility where the patient receives care in a private residence.

Note: Synchronous telemedicine services rendered via real-time, interactive audio and video telecommunication systems should not include modifier "93".

Telehealth documentation requirements

Q: Are there additional documentation requirements associated with telehealth services?

A: As a best practice, CarePlus recommends documenting in the medical record whether a visit was conducted via interactive audio telecommunication simultaneously with video telecommunication or through other virtual mechanisms, such as audio only.

Key telehealth risk adjustment information

CMS recognizes diagnoses for risk adjustment purposes under the following conditions: The visit must be an allowable inpatient, outpatient or professional service, and the visit must be a face-to-face encounter. In its May 4, 2022, HPMS memo, CMS clarified that telehealth services provided using an interactive audio telecommunication simultaneously with video telecommunication to permit real-time, interactive communication satisfies the face-to-face requirement for purposes of risk adjustment data eligibility.

	Medicare-covered services	Qualifies for MRA	Physician location	Submission POS	Common CPT and HCPCS‡ codes
Telehealth (interactive audio telecommunication simultaneously with video telecommunication)	X	X	Home/office/facility	02, 10† Use CPT telehealth modifier 95 with any POS.	99202–99215 (office or outpatient visit) G0425–G0427 (telehealth consultations, emergency department or initial inpatient)
Telephonic visit (audio only)	X		Home/office/facility	02, 10† Use CPT telehealth modifier 93 with any POS.	99202–99215
Virtual check-in (5-minute to 20-minute visit)	X	X*	Home/office/facility	Any POS	98016
E-visit (use of patient portal)	X		Home/office/facility	Any POS	99421, 99422, 99423

* CPT® code 98016 qualifies for risk adjustment encounter data system submission and should be used for virtual check-in visits that use interactive audio telecommunication simultaneously with video telecommunication. CarePlus maintains that any service rendered that is audio only does not meet the face-to-face requirement for risk adjustment. Therefore, if an audio-only visit is conducted, use the evaluation and management codes, as appropriate, as well as telehealth modifier “93” to indicate an audio-only visit.

† For a service provided via telehealth, there are two code options to indicate the POS: 1) POS 02 for telehealth services provided other than in the patient’s home, or 2) new POS 10 for telehealth services provided in the patient’s home, which is a location other than a hospital or other facility where the patient receives care in a private residence.

‡ HCPCS: Healthcare Common Procedure Coding System

Telehealth reference guide

To make working with us simpler, we have developed the reference guide below, which lists direct links to helpful telehealth information. CarePlus provides these links for informational purposes only. Given the ever-changing telehealth requirements, CarePlus does not guarantee the reliability or accuracy of information on the sites.

Telehealth reference guide	
CMS guidance	**Medicare telemedicine policy updates** Telehealth policy updates | Telehealth.HHS.gov **Medicare Learning Network Booklet on Telehealth Services** MLN901705 - Telehealth & Remote Monitoring **Telehealth FAQ** Telehealth FAQ
Annual Wellness Visit	Annual Wellness Visits Annual Wellness Visits can be conducted via telehealth (simultaneous real-time video and audio only).
Practitioner Assessment Form (PAF)	CarePlus will accept PAFs completed during a visit using a real-time, interactive audio and video telecommunications system.
Active member summary	CarePlus will accept member summary with clinical inference completed during a visit using a real-time, interactive audio and video telecommunications system.
2026 Medicare Physician Fee Schedule	Physician Fee Schedule
CMS List of Telehealth Services	List of Telehealth Services
American Academy of Professional Coders website	What Is Telemedicine and Telehealth?

HEDIS, Stars and telehealth

As with in-person visits, healthcare providers can positively impact their patient's experience by discussing Healthcare Effectiveness Data and Information Set (HEDIS®)* and Stars measures during telehealth visits. The chart below highlights how MA quality measures can be satisfied via telehealth and in-home test kits.

Clinical HEDIS measures	Can be SATISFIED by telehealth (includes audio only)	Can be SATISFIED with an in-home test kit
Breast Cancer Screening (BCS)	Yes[1]	No
Care for Older Adults – Medication Review (COA-Med)	Yes	No
Colorectal Cancer Screening (COL)	Yes[1]	Yes
Controlling Blood Pressure (CBP)	Yes	No
Chronic Kidney Disease (CKD)	Yes[4]	Yes[4]
Eye Exam for Patients with Diabetes (EED)	Yes[1]	No
Hemoglobin A1c Control for Patients with Diabetes (HBD)	Yes[1]	Yes[2]
Kidney Health Evaluation for Patients with Diabetes (KED)	No	Yes[4]
Osteoporosis Management in Women who Had a Fracture (OMW)	No	No
Statin Therapy for Patients with Cardiovascular Disease (SPC)	No[3]	No[3]
Transitions of Care		
Notification of Inpatient Admission	No	No
Receipt of Discharge Information	No	No
Patient Engagement After Inpatient Discharge	Yes	No
Medication Reconciliation Post-Discharge (MRP)	Yes	No
1	***Can be satisfied during a telehealth visit when a patient-reported service is documented in a submitted medical record***	
2	***Can be satisfied with a returned hemoglobin A1c (HbA1c) test kit results of 9% or less***	
3	***Prescription written at the time of care may and will only satisfy the associated measure when the record indicates the generic name (or brand name), strength/dose, route and date when the medication was dispensed or shipped to the member and a prescription claim billed through CarePlus is present***	
4	***Requires both eGFR (blood) and uACR (urine); home kits allowed if lab processed***	
Patient safety (Medicare Part D) measures		
Medication Adherence for Cholesterol (Statins) (MAC)	No	No
Medication Adherence for Diabetes Medications (MAD)	No	No
Medication Adherence for Hypertension (angiotensin-converting enzyme (ACE) or angiotensin-receptor blocker (ARB) (MAH)	No	No
Comprehensive Medication Review (CMR)	Yes	No
Statin Use in Persons with Diabetes (SUPD)	No[1]	No[1]
1. Prescription written at the time of care may and will only satisfy the associated measure when the record indicates the generic name (or brand name), strength/dose, route and date when the medication was dispensed or shipped to the member and a prescription claim billed through CarePlus is present		

Patient experience (Consumer Assessment of Healthcare Providers and Systems [CAHPS®] and Health Outcomes Survey [HOS]) measures, including access to care, coordination of care and patient discussion, cannot be satisfied by telehealth (includes audio only) or with an in-home test kit. However, we encourage discussion around these measures during a telehealth visit.

The information in this flyer reflects HEDIS specifications but is not meant to preclude clinical judgment. Treatment decisions should always be based on the clinical judgment of the physician or other healthcare provider.

The coding information in this document is subject to changing requirements and should not be relied on as official coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.

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CarePlus HEALTH PLANS

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