Medicare telehealth restrictions and extension updates beginning October 2025

Impacts and implications for infectious diseases physicians and their patients

Disclaimer (as of November 2025):

Major changes to Medicare telehealth occurred within the last few weeks. On Nov. 12, 2025, Congress passed and the president signed a funding bill that reopened the government and, importantly, retroactively extended Medicare telehealth flexibilities through Jan. 30, 2026. This means Medicare telehealth policies that had lapsed apply for the period of the government shutdown; or claims that were previously returned or unpaid since Oct. 1, 2025, are now once again payable under the restored waivers consistent with telehealth flexibilities that were in place before Oct. 1. Providers should watch for additional guidance from the Centers for Medicare and Medicaid Services on processing these claims and monitor for further legislative action that could impact telehealth policy after Jan. 30, 2026.

Overview

After several years of expanded access during the COVID-19 pandemic, most statutory Medicare telehealth waivers expired after Sept. 30, 2025, resulting in a significant rollback of coverage. These changes sharply limit how infectious diseases physicians may provide and bill for telehealth services under Medicare.

Major changes for telehealth

- **Home telehealth largely discontinued:** Except for behavioral health, substance use disorder and certain end-stage renal disease care, Medicare patients cannot receive telehealth in their homes.
- **Reduced provider eligibility:** Only physicians, nurse practitioners, physician assistants, certified nursing assistants, certified nursing midwives, clinical psychologists and social workers can typically bill for telehealth. Temporary eligibility for other provider types is no longer available. Qualified occupational therapists, physical therapists, audiologists and speech-language pathologists can no longer furnish telehealth services if flexibilities lapse in the future.
- **Federally Qualified Health Center and Rural Health Center telehealth:** CMS finalized a policy that FQHCs and RHCs can bill for medical services as well as behavioral health services furnished via telecommunications technology through 2026, using the Medicare physician fee schedule as the payment basis.[1]
- **Audio-only restrictions**: Audio-only telehealth services may only be furnished to patients receiving telehealth services from their homes, and CMS has finalized this policy through the end of CY 2025.

Impact on infectious diseases physicians and their patients

[1] Centers for Medicare & Medicaid Services. *Telehealth FAQ CY 2026*. CMS, 19 Nov. 2025, https://www.cms.gov/files/document/telehealth-faq-updated-11-26-2025.pdf

- **Access diminishes for urban and homebound patients**: Most non-behavioral telehealth visits (including for HIV, viral hepatitis or outpatient antibiotic management) are no longer covered outside rural regions. Home-based telehealth for infectious diseases is almost entirely unavailable under Medicare.[2]
- **Disproportionate effect on vulnerable populations:** Telehealth helped reach dual-eligible and medically underserved patients. Many now face new barriers to receiving specialty care.
- **Medicare Advantage offers some flexibility:** Private Medicare Advantage plans may still offer some expanded telehealth, but benefits differ by plan.[3]

Billing and compliance for ID physicians

- **Current claims status (as of 11/7/25):** CMS has issued interim guidance indicating that telehealth claims should be submitted as usual, and Medicare is processing and paying claims consistent with the temporarily extended telehealth flexibilities, including for eligible medical and behavioral health services furnished via telecommunication technology. However, CMS has noted that additional guidance may be forthcoming, and policies may change based on future legislative or regulatory action; ID physicians should monitor CMS communications and IDSA updates for changes that may affect payment or claim resubmission.[4]
- **ACO flexibility remains:** Physicians participating in accountable care organizations under the Medicare Shared Savings Program continue to have broader telehealth flexibility, including relief from geographic restrictions, which can help maintain access for complex infectious diseases patients when in-person care is difficult**.**
- **Documentation and disclosures:** Ensure accurate coding, including appropriate telehealth place-of-service codes and modifiers, and maintain clear documentation of modality (video vs. audio-only), originating site and clinical necessity. When coverage or payment is uncertain, such as for services at the edge of current CMS policy, consider the use of an Advance Beneficiary Notice to inform patients of potential financial responsibility in accordance with Medicare rules.

What drives these limitations: Congressional versus CMS authority

- **CMS is bound by statute but has used its full authority:** CMS implements Medicare telehealth requirements within the framework set by Congress and cannot independently eliminate statutory geographic or originating site restrictions. Within those limits, however, CMS has significantly expanded access by adding services to the telehealth list; extending and aligning flexibilities for FQHCs, RHCs and hospital outpatient departments (especially for mental health); and using innovation and payment policy authority to broaden virtual care options.
- **Updated guidance on practitioner home addresses:** In recent FAQ guidance, CMS clarified that practitioners who furnish telehealth services from their homes do not need to list their home address on their Medicare enrollment application if they have a separate physical practice location on file; different rules apply for virtual-only telehealth practitioners. This

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[2] Medicare.gov. "Telehealth Insurance Coverage - Medicare." Published: 29 September 2025 https://www.medicare.gov/coverage/telehealth

[3] Centers for Medicare & Medicaid Services. *Telehealth FAQ CY 2026*. CMS, 19 Nov. 2025, https://www.cms.gov/files/document/telehealth-faq-updated-11-26-2025.pdf

[4] "Telehealth Policy Updates." *Telehealth.HHS.gov*, Health Resources and Services Administration, 20 Nov. 2025, telehealth.hhs.gov/providers/telehealth-policy/telehealth-policy-updates.

clarification is intended to support continued use of telehealth while addressing privacy and administrative concerns related to provider enrollment.[5]
- **Potential for innovation authority:** While major changes to core telehealth restrictions still require congressional action, CMS could test additional models under its innovation authority and has already used its existing discretion to expand virtual care by FQHCs, RHCs and hospital outpatient departments for certain services, particularly behavioral health.

Congress holds the key: Only Congress can make the permanent changes needed to expand or modernize Medicare telehealth policy. Congressional authority allows for:

- **Permanent reform:** Congress can amend the Social Security Act to permanently remove geographic and originating site restrictions, expand the list of eligible telehealth providers and mandate payment parity for remote visits, thus solidifying pandemic-era flexibilities within federal law.[6]
- **Temporary extensions via appropriations:** Congress can pass appropriations bills, continuing resolutions or specific "extender" provisions to temporarily preserve or restore expanded telehealth authorities. Historically, these extensions have been included as riders on larger government funding bills. When Congress does not act to renew these authorities in appropriations legislation, expanded Medicare telehealth flexibilities lapse and revert to the more restrictive baseline.[7]
- **Retroactive relief in recent funding legislation:** In the latest government funding bill, Congress restored key Medicare telehealth flexibilities retroactively and extended them through Jan. 30, 2026, allowing CMS to process and pay telehealth claims that had been delayed or held during the lapse in authority. Going forward, similar appropriations or extender bills could again be used to reinstate or further extend telehealth authorities, with CMS reprocessing affected claims once new legislation is enacted.

What can infectious diseases physicians do now?

- **Educate your team and patients:** Communicate current limitations, billing realities and potential out-of-pocket implications for telehealth services.
- **Submit feedback and advocate:** Work with IDSA to engage Congress and CMS by joining the Member Advocacy Program. Share data and patient stories documenting how the loss of telehealth access disrupts care for ID patients.
- **Review Medicare Advantage options:** For eligible patients, review whether their plan provides broader telehealth benefits.
- **Leverage ACO participation:** If you are affiliated with an ACO, consider whether these programs enable continued telehealth options for your patients.

IDSA's advocacy priorities

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[5] Centers for Medicare & Medicaid Services. *Telehealth FAQ CY 2026*. CMS, 19 Nov. 2025, https://www.cms.gov/files/document/telehealth-faq-updated-11-26-2025.pdf

[6] "November 2025 Updates to Medicare Telehealth Policy." *eHealth Virginia*, 20 Nov. 2025, https://www.ehealthvirginia.org/november-2025-updates-to-medicare-telehealth-policy/.

[7] "Government Shutdown Ends With Legislation That Extends Medicare Telehealth Flexibilities." *American College of Cardiology*, 12 Nov. 2025, https://www.acc.org/Latest-in-Cardiology/Articles/2025/11/13/15/08/Government-Shutdown-Ends-With-Legislation-That-Extends-Medicare-Telehealth-Flexibilities.

- Push for permanent removal of Medicare geographic/originating site restrictions.
- Broaden the range of eligible telehealth providers.
- Secure payment parity for the place of service differential for telehealth and in-person visits.
- Highlight the unique needs of immunocompromised, mobility-impaired and complex infectious diseases patients in all advocacy efforts.