Telehealth – Medicare

LOB(s):	State(s):
☐ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☐ *Medicaid*	☐ *Oregon*

Medicare Policy

PacificSource is committed to assessing and applying current regulatory standards, widely used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serve as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Community Health Plans. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not authorized or contracted. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

This policy describes PacificSource Community Health Plans billing, reimbursement and coverage guidelines for Telehealth services which occur when an eligible provider and member are not at the same site. This policy is meant to outline medical and behavioral health telehealth services. The guidelines and information provided are applicable to the state in which the member's plan originated, not where the member is residing at the time of service.

For information regarding participating provider eligibility, please see the PacificSource Provider Manual.

General Guidelines and Information

PacificSource recognizes federal and state mandates in regard to Telehealth, Telemedicine, and Virtual Care. Any terms not otherwise defined in this policy are directed by the federal and state mandates.

- This is a general reference regarding PacificSource's reimbursement policy for the services described and is not intended to address every reimbursement situation
- Other factors affecting reimbursement may supplement, modify, or supersede this policy which include, but are not limited to the following:
    - Legislative mandates
    - Provider contracts

- Benefit and coverage documentation
- Other medical, behavioral health, or drug policies

- Services are subject to medical necessity, evidence-based protocols, and member's eligibility and benefit at time of service

Criteria

Medicare

Prior authorization to use a telehealth service is not required unless the service requires prior authorization when performed in-person.

In general, PacificSource follows the Center for Medicare and Medicaid Services (CMS) requirements for coverage of telehealth and telemedicine services, including eligible providers, originating site and patient location requirements, audio-only services when permitted, and temporary or permanent regulatory changes as issued by CMS. Please refer to CMS.gov for coverage criteria.

PacificSource considers telehealth services medically necessary when **ALL** of the following conditions are met:

- Synchronized video (two-way, interactive video); except when permitted by CMS, audio-only communication
  - For audio-only telehealth services, the service must meet applicable Medicare requirements, including when the patient is in the home and is not capable of, or does not consent to, the use of video technology, or when otherwise permitted for behavioral health services
- Services must be medically necessary, and member must be eligible for coverage
- Providers and originating site must be eligible for reimbursement
- Provider is eligible to furnish and bill for services under Medicare requirements
- Provider compliance with medical records requirements and provisions of HIPAA and HITECH is required for telehealth services
- Services must comply with Section 1557 of the Affordable Care Act (45 CFR Part 92) and the American Disabilities Act, including provision of accessible technology, language assistance, and reasonable accommodations

Coding Information

Reimbursement Information

- Telehealth visits will be subject to retrospective review as appropriate
- For services that a provider also bills for when done in the office (e.g., office visit E&M codes, psychotherapy visit codes), they will be processed under comparable benefits (such as office and home visits or mental health office visits), regardless of whether they were done in the office or over the phone/video. For services that a provider would only bill as telehealth (i.e., specific telephone-visit-only codes), those would fall under the telehealth/telemedicine benefit and apply the lower copay (shown as telemedicine visits on benefit summary), if applicable for the plan.

Claim Information

- Place of Service (POS) code 02 or 10 on CMS HCFA 1500 form will calculate using the facility RVU for the applicable CPT code. Telehealth performed in the urgent care setting should be billed with POS location 02, not 20
- Place of Service code 11 for telehealth claims is allowed but must be billed with either the -GT or -95 modifier
- Modifier -GT, -GQ, -93, or -95 and additional modifiers may be appended when appropriate to the CPT or HCPCS for telemedicine consultations
- Documentation for telehealth services should be the same as if services were rendered face-to-face:
    - Document if the service was provided via technology with synchronous audio/video or audio alone
    - Document where the patient and provider are located
    - Document provider is speaking to the correct person (properly identified the person on the call)
    - Consent must also be documented for the visit to be performed via telehealth (can be done annually)
    - Document if the call started out with audio/video but was completed as audio only due to technical issues

Definitions

Distant Site - The physical location of the eligible health care provider.

Eligible Providers - Provider types recognized by PacificSource who are eligible for services in the healthcare setting, are qualified health professionals, who are licensed, and are eligible for reimbursement of appropriate services via telehealth.

- In addition to provider types recognized by CMS for telehealth, PacificSource Medicare follows current Medicare requirements regarding provider eligibility for telehealth services, including Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapists (LMFT), Licensed Clinical Professional Counselors (LCPC), Licensed Mental Health Counselors (LMHC, Washington only), Federally Qualified Health centers (FQHC), and Rural Health Clinics (RHC) to be eligible providers for tele-video and telephonic services as appropriate with state law.

Originating Site - The location of the patient receiving telemedical health services. PacificSource Medicare follows current Medicare requirements for originating site and patient location eligibility, including temporary or permanent CMS flexibilities. Eligible originating sites may include, when permitted by CMS:

- Office of a qualified health care professional
- A hospital (inpatient or outpatient)
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)

- Federal Qualified Health Center (FQHC)
- A hospital based or critical access hospital based renal dialysis center, including satellites
- Renal dialysis facilities
- Skilled Nursing Facility (SNF)
- A Community Mental Health Center
- Mobile Stroke Unit
- Rural emergency hospital
- Patient Home ONLY for:
    - Diagnosis and treatment of mental health disorders
    - Treatment of substance use disorder
    - Monthly ESRD-related clinical assessments

Telehealth or Telemedicine - Consultations with a qualified healthcare professional provided in real-time over an electronic mechanism. These services are rendered to patients using electronic communications such as secure email, patient portals, and online audio and/or video conferencing

Virtual Care - an umbrella term that encompasses terms associated with a wide variety of synchronous and asynchronous care delivery modalities enabled by technology, such as telemedicine, telehealth, m-health, e-consults, e-visits, video visits, remote patient monitoring, and similar technologies. Virtual care is technology-enabled health care services in which the patient and provider are not in the same location but are rendered at the physical location of the patient.

Related Policies

Telehealth – Oregon Medicaid

Telehealth – Commercial

References

Centers for Medicare and Medicaid. (December 2025). MLN Fact Sheet: Telehealth & Remote Monitoring. Available at: https://www.cms.gov/files/document/mln901705-telehealth-services.pdf

U.S. Department of Health and Human Services. (February 5, 2026). Telehealth policy updates. https://telehealth.hhs.gov/providers/telehealth-policy/telehealth-policy-updates

U.S. Department of Health and Human Services. Office for Civil Rights. (2025). Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons. https://www.hhs.gov/civil-rights/for-individuals/disability/guidance-on-nondiscrimination-in-telehealth/index.html

U.S. Department of Justice. ADA.gov. Telehealth. https://www.ada.gov/topics/telehealth/

Appendix

Policy Number:

Effective: 5/1/2022 **Next review:** 8/1/2027

Policy type: Medicare

Author(s):

Depts.: Health Services, Provider Network; Claims;

Applicable regulation(s): SSA §1834; Consolidated Appropriations Act (CAA), 2023, 45 CFR Part 92, Americans with Disabilities Act (ADA), 42 CFR § 410.78; IDS 54-5714 and 54-1733.;

Government Ops: 6/2026