

Medicare Minute Teaching Materials — April 2026

Medicare Telehealth Coverage

1. What is telehealth?

Telehealth includes certain services that an individual receives from a health care provider outside of an in-person office visit. A telehealth service is a full visit with a provider using telephone or video technology that allows for both audio and video communication.

2. What types of services does Medicare cover as telehealth?

Medicare covers certain services when provided via telehealth. Some examples include:

- Lab test or x-ray result consultations
- Post-surgical follow-up
- Prescription management
- Preventive health screenings
- Urgent care issues like colds, coughs, and stomach aches
- Mental health treatment, including online therapy and counseling
- Treatment of recurring conditions, like migraines or urinary tract infections
- Treatment of skin conditions

Individuals can ask their doctor about telehealth options and whether getting care through telehealth would be suitable for their individual circumstances.

3. Does Medicare cover virtual check-ins?

Yes. Original Medicare Part B covers virtual check-ins, also called “brief communication technology-based services” with certain providers. These check-ins allow individuals to communicate with their providers through audio and video communication technology or by sending in photo or video images for remote assessment. Their doctor or other provider can respond by phone (audio or video), secure text messaging, email, or use of a patient portal.

Virtual check-ins are for patients who have an established relationship with their provider, and the patient must verbally consent to receive these services. **A virtual check-in is not a full appointment**, and Medicare pays for the virtual check-in at a lower rate than an in-person or telehealth appointment. A covered check-in does not relate to a medical visit within the past seven days and does not lead to a medical visit within the next 24 hours (or the soonest appointment available). Virtual check-ins are covered at 80% of the Medicare-approved amount after an individual meets the Part B deductible, and the individual owes a 20% coinsurance.

4. How is a telehealth visit different from a virtual check-in?

Virtual check-ins are separate from Medicare’s telehealth benefit. The virtual check-in is generally a brief (5-10 minute) discussion with a provider, as compared to a full telehealth visit, which is treated and reimbursed in the same way as an in-person visit. Medicare telehealth visits usually require real-time communication through audio and visual technology, while virtual check-ins can use a broader range of communication methods such as text messaging and email. Also, virtual check-ins are available to Medicare beneficiaries in all areas.

5. How did Medicare cover telehealth before the COVID-19 Public Health Emergency (PHE)?

To understand how Medicare's coverage of telehealth has changed over time, first it is important to know the coverage rules that were in place **before** the PHE. This section does not reflect current coverage flexibilities (see question 6) or possible future changes (see question 7).

Before the COVID-19 Public Health Emergency, **Original Medicare Part B** covered telehealth in very limited situations.

Locations

Outside of PHE-related flexibilities, Original Medicare beneficiaries could generally only access telehealth if they lived in a rural area and traveled from their home to a local medical facility to receive the services. They had to be at an "originating site" in an eligible geographic area, including rural health professional shortage areas (HPSA) and counties not classified as a metropolitan statistical area (MSA). Eligible originating sites included physician and practitioner offices; hospitals; critical access hospitals; rural health clinics; federally qualified health centers; hospital-based or critical access hospital-based renal dialysis centers (including satellites); skilled nursing facilities; and community mental health centers.

With these requirements, beneficiaries could not receive telehealth services in their own homes, and Original Medicare beneficiaries in urban areas were generally ineligible for telehealth. The originating site geographic limitations were only waived in circumstances where:

- Individuals required telehealth services to treat a diagnosed substance use disorder or co-occurring mental health disorder. These individuals had the option of accessing telehealth services from their home or from a medical facility.
- Individuals required telehealth services to diagnose, evaluate, or treat symptoms of acute stroke. These individuals had the option of accessing telehealth services from their home or from a medical facility.

Technology requirements

Original Medicare required that telehealth visits be conducted with interactive, two-way audio and video technology that allows for real-time communication between the practitioner and the beneficiary at the originating site. The only exception to this interactive telecommunications requirement was for federal telemedicine demonstration programs in Alaska and Hawaii, where beneficiaries could send medical information to a practitioner to review later without real-time interaction.

Practitioners

Original Medicare covered telehealth services provided by eligible practitioners, which included physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified nurse-midwives, certified registered nurse anesthetists, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.

Medicare Advantage (MA)

Medicare Advantage plans must cover all of the telehealth benefits included in Original Medicare, but they may also cover additional telehealth benefits. MA plans could offer benefits not covered by Original Medicare, such as telehealth visits provided in a beneficiary's home or telehealth services for individuals who live outside of a rural area.

6. How is telehealth currently covered?

During the PHE, telehealth coverage was temporarily expanded to include more flexibility and allow more people to receive care from their homes. These flexibilities have been extended through December 31, 2027.

Locations

Previously, only Medicare beneficiaries in rural areas could access telehealth, and they were required to travel to an authorized health care setting. With the flexibilities now, telehealth services are covered for all beneficiaries in any geographic area, and they can receive these services at home in addition to health care settings.

Technology requirements

Beneficiaries must generally still use an interactive audio and video system that allows for real-time communication with the provider. Guidance from the Department of Health and Human Services (HHS) allows providers to temporarily use any non-public facing remote technology (such as FaceTime, Zoom, or Skype) to communicate with their patients.

Limited telehealth services can be delivered using audio only, via audio-only telephone or a smartphone without video. These services include counseling and therapy provided by an opioid treatment program, behavioral health care services, and patient evaluation and management.

Practitioners

Previously, Medicare only covered telehealth services provided by eligible practitioners (see question 5). With the current flexibilities, any health care professional that is eligible to bill Medicare for professional services can provide and bill for telehealth services. This includes professionals who previously could not receive payment for Medicare telehealth services, such as physical therapists, occupational therapists, and speech language pathologists.

Services

Original Medicare expanded the list of covered telehealth services during the PHE, including emergency department visits, physical and occupational therapy, and certain other services. For example, a doctor can use telehealth in place of the face-to-face visits required to prescribe Medicare-covered home health care. If a beneficiary has questions about what services they can receive via telehealth, they should ask their doctor.

Medicare Advantage

Medicare Advantage plans can further expand coverage and reduce or waive cost-sharing for telehealth services as part of their overall plan design.

In summary, through December 31, 2027, telehealth services are:

- Covered for all beneficiaries in any geographic area, at home in addition to health care settings
- Sometimes delivered using audio only
- Provided by any health care professional that is eligible to bill Medicare

7. Will the expanded coverage of telehealth end after the extension expires?

After December 31, 2027, most telehealth services will again be more limited unless Congress acts. For now, only some broader telehealth coverage has been made permanent.

After December 31, 2027, telehealth services will be:

- Still available regardless of geographic area for certain types of care
 - For example: Behavioral/mental health care, monthly End-Stage Renal Disease (ESRD) visits for home dialysis, diabetes self-management training, and Medicare nutrition therapy
- Still able to be delivered using audio-only communication platforms for behavioral/mental health care
- Subject to pre-PHE restrictions for other types of care

Note that after December 31, 2027, beneficiaries will be required to have an in-person, non-telehealth visit within 6 months before their first mental health service via telehealth. After the first mental health telehealth service in the beneficiary's home, there must be an in-person, non-telehealth service within 12 months of each mental health telehealth service. These requirements do not apply to beneficiaries who were receiving behavioral health services via telehealth before December 31, 2027.

8. What costs do Medicare beneficiaries pay for telehealth?

Original Medicare covers telehealth services under Part B. After beneficiaries meet the Part B deductible (\$283 in 2026), they pay 20% of the Medicare-approved amount for the service from providers who accept Medicare assignment. Medicare Advantage beneficiaries should contact their plan to learn about their telehealth costs.

9. What is remote patient monitoring?

Remote patient monitoring (RPM) is the ability for health care providers to monitor certain parts of a person's health from their home. Providers may collect data like heart rate, blood glucose, blood pressure, or breathing rate, and then use it to oversee a person's treatment plan and identify potential issues early. RPM can reduce the need for in-person visits, cut down on travel costs, and limit exposure to illness, which can be especially helpful for people with chronic conditions or mobility challenges. While telehealth connects patients and providers for virtual visits, RPM provides continuous insights into a patient's health status between appointments. Legitimate RPM involves using medical devices such as scales, glucose monitors, blood pressure cuffs, cardiac monitoring devices, and other equipment ordered and prescribed based on medical need.

At the same time, RPM may not be appropriate or necessary for every patient, and it should be used as part of a broader care plan. Patients should understand what data is being collected, how it will be used, and any potential costs or billing implications.

10. What are the potential risks and fraud related to RPM?

Although RPM can be a valuable tool when used appropriately, there are situations where services may be misused or billed improperly. Some companies may attempt to enroll Medicare beneficiaries in RPM services or provide devices without a clear medical need or without the patient's full understanding or consent.

Be cautious of unsolicited offers or marketing that pressures you to sign up for RPM services or share personal information. Potential warning signs include:

- You see charges on your Medicare statements for remote monitoring you didn't need, you didn't get, you didn't agree to, or that were from a provider you do not know.
- You are offered a "free" device that tracks your daily steps, like a smartwatch, in exchange for your Medicare number or other personal information.
- You are told RPM services are free to Medicare beneficiaries and then RPM services are billed to Medicare.
- Your doctor's office calls to ask how you are doing. Later, you notice they billed the phone call to Medicare as an RPM service.

To protect yourself, always confirm that RPM services are recommended by your trusted health care provider, ask questions about costs and billing, and review your Medicare statements carefully.

If you think you've experienced potential Medicare fraud, errors, or abuse, contact your Senior Medicare Patrol (SMP). Contact information for your local SMP is on the last page of this document.

11. Who should I contact with questions?

Your health care provider: Speak with your trusted doctor or other health care provider to learn about the telehealth services they offer and if they may be appropriate for your health care needs.

State Health Insurance Assistance Program (SHIP): Contact your SHIP if you have questions about Medicare's telehealth coverage. Contact information for your local SHIP is on the last page of this document.

Senior Medicare Patrol (SMP): Contact your SMP if you have experienced potential Medicare fraud, errors, or abuse. SMPs empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse. Contact information for your local SMP is on the last page of this document.

Your Medicare Advantage plan: Contact your Medicare Advantage plan if you have questions about its coverage and costs related to telehealth services.

SHIP case example

Joan has Original Medicare and lives in a big city. She's taken a prescription medication for anxiety for the last few years, and a psychiatric mental health nurse practitioner (PMHNP) prescribes the medication. They usually have two appointments per year, where the PMHNP makes sure the medication is still working for Joan. Joan's biannual appointment with her PMHNP is this week, but she's feeling really sick and knows she is likely contagious. Joan would prefer to stay home and rest but is worried about missing the appointment and having to wait for her next prescription refill.

What should Joan do?

- Joan should contact her health care provider (in this case, the PMHNP). The PMHNP may be able to change their appointment to a telehealth visit, so that Joan can stay home while sick.
 - Even if the PMHNP cannot offer telehealth, they can reschedule the appointment and submit Joan's next prescription refill.

- If Joan has more questions about Medicare’s coverage of telehealth, she can contact her State Health Insurance Assistance Program (SHIP).
 - If Joan doesn’t know how to contact her local SHIP, she can visit www.shiphelp.org or call 877-839-2675.
- A SHIP counselor can explain the current flexibilities related to Medicare’s coverage of telehealth. Even after 2027, it seems likely that Joan will continue to be able to get Medicare coverage for telehealth appointments with her PMHNP, regardless of the fact that she does not live in a rural area. This is because the service is for behavioral/mental health care and provided by an eligible practitioner.

SMP case example

Doreen gets a call from a local medical equipment store. The store member says they’re having a promotion and offering Medicare beneficiaries a free smart watch that can track her steps and heart rate. Doreen agrees to receive the watch, and in exchange provides her address and her Medicare number. The watch is soon mailed to her and Doreen happily uses it. A few months later, she looks at her Medicare Summary Notice and sees some unfamiliar charges. A doctor she’s never heard of has been billing her Medicare for monthly remote patient monitoring services. Even though she isn’t being charged, she feels confused and uncomfortable because she wasn’t aware she signed up for a monitoring service.

What should Doreen do?

- Doreen should call her Senior Medicare Patrol (SMP) to report the situation.
 - If Doreen doesn’t know how to contact her local SMP, she can call 877-808-2468 or visit www.smpresource.org.
- The SMP team member will encourage Doreen to continue the good habit of reading her Medicare statements and finding suspicious charges, as well as taking additional precautions in the future:
 - Discussing her need for medical equipment with her trusted health care provider
 - Not accepting “free” or promotional offers in exchange for her personal information
 - Protecting her Medicare number
- The SMP team member will report the suspected fraud to Medicare and the proper authorities.
- Doreen should not continue using the smart watch as it may be tied to the potentially fraudulent RPM claims.

Local SHIP Contact Information	Local SMP Contact Information
<p>SHIP toll-free: 800-247-4422 SHIP email: idahoshiba@doi.idaho.gov SHIP website: shiba.idaho.gov</p> <p>To find a SHIP in another state: Call 877-839-2675 and say “Medicare” when prompted or visit www.shiphelp.org.</p>	<p>SMP toll-free: 800-247-4422 SMP email: Idahoshiba@doi.idaho.gov SMP website: Medicare Fraud Prevention - Idaho Commission on Aging</p> <p>To find an SMP in another state: Call 877-808-2468 or visit www.smpresource.org.</p>
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