

Publications

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CMS Extends Telehealth Claims Hold: What Hospitals and Providers Need to Know

Key Takeaways:

- The Centers for Medicare & Medicaid Services has instructed Medicare contractors to hold payment for telehealth claims dated Oct. 1, 2025, or later.
- Absent congressional action, telehealth services that no longer meet Medicare coverage requirements may not be reimbursed.
- Providers should consider assessing where coverage has changed and whether to issue Advance Beneficiary Notices for at-risk services.

In response to the expiration of key Medicare telehealth flexibilities, the Centers for Medicare & Medicaid Services (CMS) released a Special Edition: Claims Hold Update on Oct. 15, 2025, instructing all Medicare Administrative Contractors (MACs) to continue holding payment for telehealth claims. The agency's update confirms that MACs should not process claims with dates of service on or after Oct. 1, 2025, extending CMS's earlier guidance issued when the Medicare telehealth flexibilities expired on Sept. 30, 2025.

The temporary hold is designed to give Congress time to act, but absent legislation, providers may need to shift care delivery models to stay compliant or potentially face claims denials. This alert outlines what's changed, what's at risk and how providers can prepare amid ongoing uncertainty.

What's Changed: Expired Flexibilities and Reinstated Restrictions

As described in Polsinelli's Oct. 1 update, *Telehealth in Limbo: Government Shutdown Cuts off Medicare Flexibilities*, the budgetary impasse that led to the federal government shutdown also reinstated long-standing statutory restrictions on Medicare telehealth coverage. As of Oct. 1, the following limits are back in effect:

- Beneficiaries must be located in a rural area and physically present in a medical facility to receive most covered telehealth services.
- Certain providers — such as physical therapists, occupational therapists, speech-language pathologists and audiologists — are excluded from delivering Medicare-covered telehealth services.

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- Many home-based telehealth services that were previously allowed under temporary PHE flexibilities are no longer reimbursable.
- For certain mental health telehealth services delivered via telehealth to patients at home, an in-person visit is required within six months prior to the initial telehealth service and annually thereafter

Why It Matters: Claims Hold Buys Time, but Not Certainty

CMS has instructed MACs to continue temporarily holding impacted telehealth claims to avoid a large claim reprocessing effort if Congress reinstates the flexibilities retroactively. Absent legislation, however, providers face financial risk: claims for telehealth services no longer covered by Medicare as of Oct. 1, 2025, may go unpaid.

To prepare, practitioners should evaluate whether they can shift their care delivery to comply with the current requirements (*i.e.*, without use of the flexibilities) or consider issuing an Advance Beneficiary Notice of Noncoverage (ABN) when delivering telehealth services that are no longer covered under current Medicare rules. An ABN notifies beneficiaries in advance that they may be financially responsible for the cost of a service Medicare is not expected to cover.

ABNs may be especially warranted when providing telehealth services to beneficiaries at home or in non-rural areas or when using modalities or provider types no longer allowed under Medicare telehealth policy.

CMS's Latest Guidance: FAQ Offers Clarity for Mental Health Providers

In addition to extending the claims hold, CMS updated its Telehealth FAQs Calendar Year 2025 to reflect the expiration of telehealth flexibilities. The FAQs confirm current Medicare telehealth policy requirements and offers insight into CMS's interpretation of key statutory provisions, particularly for mental health providers.

Importantly, the FAQs confirm that mental health patients receiving telehealth services prior to Oct. 1, 2025, are considered established patients. This means providers will not need to show proof of an in-person visit in the preceding six months to establish Medicare coverage, and patients will only be required to meet the annual in-person visit requirements going forward.

Looking Ahead: Preparing Now Amid Legislative Uncertainty

CMS's extended claims hold reflects its intent to preserve the ability to pay claims retroactively if Congress acts, but without legislation, affected services will not be payable. As a result, providers should be prepared for the possibility that they will have to absorb the financial impact or pursue direct payment from beneficiaries.

Currently, there is no clear timeline for resolution. Providers offering Medicare telehealth services should closely monitor developments and consider reviewing their internal billing, documentation and patient communication practices in the interim.

Our team is actively tracking legislative activity and any further regulatory guidance from CMS related to the Medicare telehealth payment environment. If you have questions about how this claims hold impacts your organization's operations and revenue, or if you need assistance evaluating the use of ABNs and other compliance strategies, we are here to help.

