Reimbursement Tips:

FQHC Requirements for Virtual Communication Services (VCS)

Overview

Virtual Communication Services (VCS) refer to healthcare services provided remotely, typically via digital platforms including smartphones, tablets, email, secure messaging, and patient portals. These services benefit patients by offering greater accessibility to healthcare, reducing the need for in-person visits, and enabling timely consultations, which can improve convenience and continuity of care, especially for those in rural or underserved areas.

VCS and telehealth services both involve remote healthcare delivery, but they differ in scope and complexity. VCS are brief, non-comprehensive interactions that involve remote consultations, like a physician reviewing a patient's submitted images or a quick phone check-in. VCS are often used for specific issues that do not require a full clinical visit, offering convenience for minor concerns. Telehealth services, on the other hand, encompass a broader range of remote healthcare, including live audio and video interactions and full clinical assessments. Telehealth can address more complex conditions and involve a more in-depth exchange between patients and their providers. For more information about telehealth, please see also the NACHC Reimbursement Tips: "Medicare Extended FQHC Telehealth Services".

VCS are billed to Medicare by FQHCs via G0071 and are reimbursed separately from FQHC Prospective Payment System (PPS) qualifying services. This Tip Sheet provides FQHCs with simplified, easy-to-understand instructions for providing and billing Medicare for Virtual Communication Services. Also see NACHC resource: *Medicare Billing Lingo, Defined!* for definitions of terms used throughout this document.

Eligible Patients

- Medicare Part B beneficiaries
- Established FQHC patients
- Provide verbal or written consent prior to receiving services

Initiate VCS services with the practitioner using one of the following methods: telephone call, secure patient portal, text messaging system, email, mobile application, in-person request.

Note: During the COVID-19 Public Health Emergency "PHE", VCS was available to new patients not seen in the FQHC within the previous 12 months; however, that flexibility expired at the end of the PHE on May 11, 2023. Only established FQHC patients may receive VCS services.

Authorized Billing Providers

Who they are:

- Physicians (MD,DO)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Clinical Nurse Midwives (CNM)

  Note: Virtual communication services are part of the Evaluation and Management (E/M) services category, and providers must therefore be qualified to perform and bill for E/M level services in the state where they practice. A VCS can occur with any FQHC practitioner as opposed to the practitioner who has previously treated the patient.

What they do:

- ✔ Obtain patient consent before proceeding with the interaction.
- ✔ Personally furnish virtual communication services which require FQHC practitioner licensure, scope of practice, education and training at the federal and/or state level.

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Auxiliary Personnel

Who they are (examples):

- Social Workers
- Nurses (Clinical Nurse Specialist (CNS), Registered Nurse (RN), Licensed Practical Nurse (LPN))
- Medical Assistants

Note: Only a qualified FQHC practitioner may furnish VCS encounters. Services furnished by auxiliary personnel (for example, nurses, medical assistants, or other clinical personnel acting under the supervision of the FQHC practitioner) are considered incident to the visit and are included in the per-visit payment.

What they may do:

✔ Obtain patient consent under direct supervision if not obtained by the authorized billing provider.

Note: During the PHE, auxiliary personnel were permitted to obtain patient consent under general supervision; however, that flexibility expired at the end of the PHE on May 11, 2023. Consent can still be obtained by auxiliary personnel but under direct supervision of the authorized provider.

Services Elements, Coding & Billing

CODE	*Service Elements*	*Service Provider*	*FQHC Medicare Billing Code & Rate*
G2010	Remote evaluation of recorded video and/or images ("store and forward") submitted by an established patient; interpretation and follow-up • **Established patients only**: Services are intended for patients already under the care of the provider, ensuring familiarity with their medical history. • **Includes interpretation with follow-up within 24 business hours**: Providers must evaluate the submitted materials (e.g., video or images) and communicate results or next steps promptly. • **Used to evaluate if a more extensive E/M visit is necessary**: Helps determine whether the patient's issue requires a more detailed evaluation via an in-person visit or a telehealth consultation (i.e., an E/M service). • **May not originate from a related E/M service within the previous 7 days**: This is a key requirement, as the service should not be a follow-up to a related E/M service within the last week. • **May not lead to an E/M service or procedure within the next 24 hours or soonest available appointment**: This ensures that the service does not directly lead to an immediate or scheduled in-person or more extensive telehealth visit within a short time frame.	Authorized billing provider only	G0071: $13.91 *There is no limit to the number of times a G0071 may be billed.*
CPT 98016 *Replaces G2012*	Brief, patient initiated, communication technology-based services ("**virtual check-in**") by a physician or other qualified practitioner; established patients only; 5-10 minutes in duration of medical discussion • All service elements and criteria as listed for G2010 • 5-10 minutes in duration of medical discussion: VCS are designed to be short consultations, typically lasting between 5 to 10 minutes, focusing on a specific issue. *Notes:* • *Do not report in conjunction with 98000-98015* • *Do not report if services are less than 5 minutes of medical discussion*		

Payment for G0071 is based upon the average of the 2025 national non-facility Physician Fee Schedule (PFS) payment rates for G2010 and 98016. No Geographical Adjustment factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied; FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI. Code descriptions taken from the AMA's CPT 2025 Manual, Professional Edition and from the AAPCs HCPCS Level II 2025 Manual.

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Patients pay 20% coinsurance based upon the lesser of the submitted charges or the local payment rate for G0071. Coinsurance may be covered in part or in full by secondary coverage (Medigap, private, or Medicaid). Coinsurance may be "slid" commensurate with the sliding fee discount program (SFDP) policy of the health center (see Sliding Coinsurance for CMS/Medicare Care Management for more information).

G0071 can be billed either alone or on the same claim as other billable visits so long as VCS was not furnished within the previous 7 days or within the 24 hours, or soonest available appointment. VCS services may be billed in the same month as Transitional Care Management (TCM), general Behavioral Health Integration (BHI), Psychiatric Collaborative Care Model (Psychiatric CoCM), Chronic Pain Management (CPM), or any of the chronic care management services (Chronic Care Management (CCM)/Complex Chronic Care Management (CCCM)/Primary Care Management (PCM)) as long as requirements of each are met.

As of January 1, 2025, CMS began offering Advanced Primary Care Management (APCM) services as a chronic care management benefit. FQHCs can provide and bill for APCM services. Communication-technology-based services are included in the APCM code bundle, meaning VCS cannot be billed separately when provided as part of the APCM.

It is important that FQHCs check with each payer for the coding and billing requirements. Coverage of VCS varies by state for Medicaid and by commercial payor policies.

Documentation

Be sure to capture the following documentation elements when billing for virtual communication services:

- ✔ Patient consent
- ✔ Summary of email, message, recordings, or images provided by the patient to initiate VCS
- ✔ Primary reason for the patient's communication
- ✔ Date of the rendered response, including interpretation, and the mode (telehealth audio-visual, audio-only, or in-person).
- ✔ Total time spent on medical discussion
- ✔ Any updates to existing treatment plans
- ✔ Confirmation that services did not originate from a related E/M within 7 days of VCS
- ✔ Confirmation that VCS will not lead to a subsequent E/M service or procedure within the next 24 hours or soonest available appointment.

References

- AMA. 2025 CPT Codebook
- AAPC. 2025 HCPCS Level II Codebook
- CMS CY 2025 Physician Fee Schedule Medicare Final Rule. https://www.federalregister.gov/public-inspection/2024-25382/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule
- Medicare Claims Processing Manual. Chapter 9: Rural Health Clinics/Federally Qualified Health Centers https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf
- Medicare Benefit Policy Manual. Chapter 13: Rural Health Clinics/Federally Qualified Health Center https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf
- Specific Payment Codes for FQHC PPS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

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