



PAYMENT

Reimbursement Tips:

FQHC Requirements for CMS Virtual Communication Services (VCS)

Virtual Communication Services (VCS) support providers who engage in “virtual check-ins” via telephone or evaluate and interpret images/audio submitted by patients for over five (5) minutes for condition(s) unrelated to recent visits and that do not result in an immediate visit.



Program Requirements

Virtual Communication Services (VCS) or “virtual check-ins” allow for communications-based technology or remote evaluation services to be provided to a patient who has had a billable visit within the previous year. VCS must include at least 5 minutes of services for a condition(s) NOT related to a visit in the past seven (7) days and that does not result in an appointment in the next 24 hours or next available appointment slot (Medicare pays for those services as part of FQHC per-visit payment). These services are in lieu of an FQHC office visit.

During the COVID-19 Public Health Emergency (PHE), CMS expanded the payment definition of Virtual Communication Services to include online digital evaluation and management services for FQHCs. CMS had been paying providers separately for these services under the physician fee schedule and expanded these same flexibilities to FQHCs. CMS defines online digital evaluation and management services as “non-face-to-face, patient-initiated, digital communication using a secure patient portal, that requires a clinical decision that otherwise would have been provided in the office”.



Patient Eligibility & Consent

VCS must be initiated by the patient (i.e., via telephone, online, integrated audio/video system, or sending an audio or visual message/image). The provider's evaluation and response can be through a store and forward method (e.g., telephone audio/video, secure text messaging, email, patient portal) and must occur within 24 business hours of the initial patient contact. VCS are not the same as telehealth services. The major distinction between the two is that telehealth services are a substitution for an in-person visit.

Patient consent is required to bill for VCS services. Patient consent may be written or verbal and must be documented in the medical record. FQHCs are required to inform patients that coinsurance applies. Health centers should provide information on the

availability of assistance to qualified patients in meeting their cost sharing obligations, or any other applicable financial assistance.



Timeframe & Services

Minimum documentation

HCPCS code G2010 has no minimum time requirement, while G2012 must last at least 5 minutes. Neither code has any CMS/Medicare frequency restrictions. However, as G0071 is required to be used for Medicare, and is the equivalent of G2010/G2012, a minimum of 5 minutes must be documented for both G2010 and G2012.

The services codes for the expanded VCS services allow for cumulative time to be counted toward the minimum for the time range for each code. The code description in the Coding & Billing section illustrates those definitions.

VCS requirements

“Brief communication technology-based service, i.e. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion”.

For online digital evaluation and management services (CPT codes 99421, 99422, 99423), the service time of 5 or more minutes, as defined by the code level description, may be cumulative time during the 7-day service window. These are brief, online E/M services in a secure patient portal and are commonly referred to as 'e-visits. All codes associated with VCS are for a minimum 7-day period which means that they may not be billed more than once every 7 days. Digital Communication Services are furnished through a patient portal. A clinical decision is furnished for these services.

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PHE Exception.

- VCS can be furnished to both new and established patients.
- Patient consent is still required but can be obtained during the same time services are provided whether in-person or via telehealth. If via telehealth, consent can be obtained through any qualified health professional working within their scope.
- Because VCS may be provided to new patients, the requirement that a patient has had a billable visit in the past 12 months does not apply.
- VCS must be initiated by the patient, but a provider can educate a patient about these services and a patient can then request them.
- Payment for VCS includes digital assessment services: CPT codes 99421, 99422, 99423 billed by FQHCs using HCPCS code G0071.

Authorized Provider/Staff

VCS services must be performed personally by an authorized CMS/Medicare provider. Nurses, health educators, or other clinical staff that provide similar services should not report this service under the provider's billing number as incident-to/direct supervision. The FQHC practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or the patient portal. The electronic contact a provider has with a patient as part of VCS is expressed in some CMS/Medicare language as "store and forward data".

TREATING (BILLING) PROVIDER					
MD or DO	Non-Physician Practitioners				
	NP	PA	CNM	Clinical Psychologists	Licensed Clinical Social Workers
X	X	X	X	X	X

Medical Doctor (MD) or Doctor of Osteopathy (DO) | Non-Physician Practitioners include: Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Clinical Psychologists, and Clinical Social Workers.

Documentation

VCS document requirements

- Primary reason for the patient's communication
- Information about stored images
- Any details discussed, such as medications, recommendations, and/or referrals.

- Total time for the interaction (5 minutes or longer).
- Any updates made to existing treatment plans.

Documentation should ensure consultation was not directly related to a recent visit within the last seven (7) days and that no appointment was made within 24 hours or for the first available time slot.

VCS is not reported if the health center calls the patient, unless the call was made in response to a patient who has sent images/video to the provider for review and the provider is responding to the patient with his/her interpretation and/or recommendations. This "store and forward" method could include information shared through patient portals.

Coding & Billing

For Medicare patients, FQHCs are required to **utilize HCPCS code G0071** which, for non-Medicare payers, is the equivalent of HCPCS codes G2012/G2010 for capturing virtual communication services. It is **recommended that providers select CPT® code G2012 and/or G2010 for virtual check-ins, and the revenue cycle management (RCM)/billing team crosswalk this CPT code with the G0071** which is required for FQHCs. This will afford the FQHC an optimal coding and billing opportunity when billing non-Medicare payers, which most likely will only accept G2012/G2010 rather than G0071.

CMS provides the following definitions for the VCS service codes:

- **G2010** (remote evaluation services). Remote evaluation of recorded video and/or images submitted by the patient (i.e., store and forward), including interpretation and follow-up with the patient within 24 business hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
- **G2012** (communication technology-based services). Brief communication technology-based service, i.e. virtual check-in by a MD/DO or other qualified healthcare professional who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- **99421** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes.

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- **99422** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes.
- **99423** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Payment for G0071 is based upon the average of the national non-facility Physician Fee Schedule (PFS) payment rates for G2010, G2012, 99421, 99422, and 99423).

WHAT PROVIDER CODES	Services	What FQHC bills to CMS	CMS/Medicare 2022 Fees
G2010/ G2012	Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a FQHC practitioner and patient, or 5 minutes or more of remote evaluation of recorded video and/or images by a FQHC practitioner, occurring in lieu of an office visit; FQHC only.	G0071	\$23.88*
CPT 99421 99422 99423	Online digital evaluation and management services, for an established patient, for up to 7 days.*	G0071	\$23.88

Note: Rates here are based on the 2022 Medicare Physician Fee Schedule (PFS); 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 upon the GAF/GPCI.

**Digital assessment services are payable for the duration of the COVID-19 PHE.*

G0071 can be billed either alone or on the same claim as other billable visits. 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), or Chronic Care Management (CCM) as long as requirements of both are met.

References

- The primary reference document for FQHCs reporting VCS services on Medicare Part B patients is found in the [CMS Benefits Policy Manual Chapter 13 Section 240](https://www.cms.gov/Medicare/Policy/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf) and was new for 2019.
- CMS. Virtual Communication Services FAQ's <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf>.
- CMS. Medicare Learning Network. Communication Technology Based Services and Payment for Rural Health Clinics (RHCs) and Federal Qualified Health Centers (FQHCs). <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10843.pdf>
- COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>
- CMS Medicare Learning Network. New & Expanded Flexibilities for FQHCs during the COVID-19 PHE. <https://www.cms.gov/sites/default/files/2022-01/SE20016.pdf>

