

# REIMBURSEMENT TIPS

Learner Roles:

Clinical & Quality  
Operations & Administration  
Patient & Community Support

Learner Level

100

200

300



## Helpful Resources:

- [Medicare Billing Terms Made Simple](#) for definitions of terms used throughout this document
- [Medicare Extended FQHC Telehealth Services Reimbursement Tips](#) for more information on telehealth for medical services, which have NOT been permanently included in Medicare guidelines
- [Sliding Coinsurance for Medicare Care Management Services](#) for more information on sliding fee discounts

## What You'll Learn from This Guide

- ✓ Understand the purpose and appropriate use of VCS
- ✓ Identify eligible patients, authorized practitioners, and consent requirements for VCS
- ✓ Apply correct coding, billing, and documentation rules for FQHCs



## Payment

# 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 clinical communication, such as a practitioner reviewing patient-submitted images or engaging in a brief patient-initiated communication. 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. VCS are not telehealth services.

VCS are billed to Medicare by FQHCs and are reimbursed separately from FQHC Prospective Payment System (PPS) qualifying services.

## Eligible Patients

- Medicare Part B beneficiaries
- Established FQHC patients
- Provide verbal or written consent prior to or at initiation of services
- Initiate VCS 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. That flexibility expired at the end of the PHE on May 11, 2023. Only established FQHC patients may receive VCS.*

## Authorized Billing Providers

In the FQHC setting, virtual communication services may be tied to Evaluation and Management (E/M) services or may be furnished as non-E/M-based services, and the practitioner eligibility requirements differ accordingly.

E/M-BASED VCS G2010, 98016	Non-E/M-Based VCS G2250
Authorized FQHC practitioners who are qualified to furnish and bill E/M services, including: <ul style="list-style-type: none"> <li>• Physicians (MD, DO)</li> <li>• Nurse Practitioners (NP)</li> <li>• Physician Assistants (PA)</li> <li>• Clinical Nurse Midwives (CNM)</li> </ul>	Authorized FQHC practitioners who are eligible to furnish covered non-E/M services to Medicare, including: <ul style="list-style-type: none"> <li>• Clinical Psychologists (CP)</li> <li>• Clinical Social Workers (CSW)</li> <li>• Marriage &amp; Family Therapists (MFT)</li> <li>• Mental Health Counselors (MHC)</li> </ul>
These services must be furnished within the practitioner’s scope of practice and Medicare benefit category and require the practitioner to be qualified to furnish and bill E/M services.	These services must be furnished within the practitioner’s scope of practice and Medicare benefit category and are not subject to E/M qualification requirements.

*Note: A VCS can occur with any qualified 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 VCS which require FQHC practitioner licensure, scope of practice, education and training at the federal and/or state level

## Auxiliary Personnel

Who they are (examples):

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

*Note: Only a qualified FQHC practitioner may personally furnish VCS. 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 practitioner's service and are included in the FQHC per-visit payment.*

What they may do:

- ✓ Obtain patient consent under general supervision if not obtained by the authorized billing provider

*Note: Consent may be obtained by auxiliary personnel under general supervision of the authorized provider. The person receiving consent can be an employee, independent contractor, or leased employee. Consent may be verbal or written and obtained prior to or at initiation of services.*

## Service Elements, Coding, & Billing

CODE	Service Elements	Service Provider	FQHC Medicare Billing Code & Rate
G2010	<p>Remote evaluation of recorded video and/or images ("<b>store and forward</b>") submitted by an established patient; interpretation and follow-up</p> <ul style="list-style-type: none"> <li>• <b>Provider:</b> Authorized to furnish and bill E/M services to Medicare</li> <li>• <b>Established patients only:</b> Services are intended for patients already under the care of the provider, ensuring familiarity with their medical history</li> <li>• <b>Includes interpretation with follow-up within 24 business hours:</b> Providers must evaluate the submitted materials (e.g., video or images) and communicate results or next steps promptly</li> <li>• <b>Used to evaluate if a more extensive E/M visit is necessary:</b> Helps determine whether the patient's issue requires a more detailed evaluation via an in-person visit or a telehealth consultation (e.g., an E/M service)</li> <li>• <b>May not originate from a related E/M service within the previous 7 days:</b> This is a key requirement, as the service should not be a follow-up to a related E/M service within the last week</li> <li>• <b>May not lead to an E/M service or procedure within the next 24 hours or soonest available appointment:</b> 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</li> </ul>	Authorized E/M billing provider only (physicians, NPs, PAs, CNMs)	G2010: \$13.03

CODE	Service Elements	Service Provider	FQHC Medicare Billing Code & Rate
<b>G2250</b>	Remote assessment of recorded video and/or images submitted by an established patient (" <b>store and forward</b> "); interpretation and follow-up (non-E/M services) <ul style="list-style-type: none"> <li>• <b>Provider:</b> Authorized to furnish and bill non-E/M services to Medicare (that is, practitioners who are not in an E/M billing benefit category)</li> <li>• <b>Established patients only:</b> Services are intended for patients already under the care of the provider, ensuring familiarity with their medical history</li> <li>• <b>Includes interpretation with follow-up within 24 business hours:</b> Providers must evaluate the submitted materials (e.g., video or images) and communicate results or next steps promptly</li> <li>• <b>Used to evaluate if a more extensive non-E/M visit is necessary:</b> Supports clinical decision-making regarding whether additional non-E/M service are needed, without an initiating E/M visit</li> <li>• <b>May not originate from a related non-E/M service within the previous 7 days:</b> This is a key requirement, as the service must be distinct and not part of ongoing or recently furnished related care</li> <li>• <b>May not lead to an E/M service or procedure within the next 24 hours or soonest available appointment:</b> 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</li> </ul>	Authorized non-E/M provider only (CPs, CSWs, MFTs, MHCs)	G2250: \$13.03
<b>CPT 98016</b> <i>Replaced G2012 in 2025</i>	Brief, patient initiated, communication technology-based services (" <b>virtual check-in</b> ") by a physician or other qualified practitioner; established patients only; 5-10 minutes in duration of medical discussion <ul style="list-style-type: none"> <li>• Service elements and eligibility criteria are similar to G2010, except where CPT 98016-specific time and reporting rules apply</li> <li>• <b>5-10 minutes in duration of medical discussion:</b> VCS are designed to be short consultations, focusing on a specific issue</li> </ul> <p><i>Notes:</i></p> <ul style="list-style-type: none"> <li>• Do not report in conjunction with 98000-98015</li> <li>• Do not report if services are less than 5 minutes of medical discussion</li> <li>• When services lead to an E/M service on the same calendar date, and when time is used to select the E/M service level, the time from 98016 can be added to the total E/M service time</li> </ul>	Authorized E/M billing provider only (physicians, NPs, PAs, CNMs)	98016: \$17.37

The reimbursement rate is based upon the 2026 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 on the GAF/GPCI. Code descriptions taken from the AMA's CPT 2026 Manual, Professional Edition and from the AAPCs HCPCS Level II 2026 Manual.

For CY 2026, FQHCs must report individual services codes for VCS rather than the bundled G0071 code, beginning January 1, 2026. CMS also determined that beginning January 1, 2026, FQHCs can furnish and receive payment for G2250 services. Do not confuse G2250 with G2010, which describes the same asynchronous review of patient-submitted images or video but is explicitly tied to E/M services and may only be furnished by providers authorized to bill E/M to Medicare; G2250 applies to non-E/M services furnished by practitioners outside an E/M billing benefit category.

Patients pay 20% coinsurance based upon the lesser of the submitted charges or the local payment rate for individual service codes. 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.

VCS may be billed alone or on the same claim as other billable FQHC visits, provided the VCS was not related to an E/M service furnished within the previous 7 days and does not result in an E/M service or procedure within the next 24 hours or the 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. When a Medicare beneficiary is enrolled in APCM, VCS described by HCPCS G2010, HCPCS G2250, and CPT 98016 are included in the APCM payment and may not be billed separately. These services remain separately payable only for beneficiaries who are not enrolled in 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, portal message, recordings, or images provided by the patient to initiate the VCS
- ✓ Primary reason for the patient's communication
- ✓ Date of the rendered response, including clinical interpretation and follow-up, and the mode or response (e.g., asynchronous messaging, telehealth audio-visual, audio-only, or in-person follow-up, if applicable)
- ✓ Total time spent on medical discussion, when required for the reported code
- ✓ Any updates to existing treatment plans, if applicable
- ✓ Confirmation that services did not originate from a related E/M within the previous 7 days
- ✓ Confirmation that VCS did not result in an E/M service or procedure within the next 24 hours or soonest available appointment, as applicable to the reported code

### References

- AMA. 2026 CPT Codebook
- AAPC. 2026 HCPCS Level II Codebook
- CMS. CY 2026 Physician Fee Schedule Medicare Final Rule. <https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other>
- 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>
- CMS Telehealth & Remote Patient Monitoring. MLN 901705. <https://www.cms.gov/files/document/mln901705-telehealth-remote-patient-monitoring.pdf>
- 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 Centers. <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>