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 (E/M) 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". At the end of the PHE, May 11, 2023, FQHCs will no longer be allowed to bill for online digital E/M services.

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 billing FQHC VCS to 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 temporarily allowed online digital E/M 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. A clinical decision is furnished for these services.

© 2020 National Association of Community Health Centers. All rights reserved. | QualityCenter@nachc.org | May 2023

MEDICARE: END OF PHE VIRTUAL COMMUNICATION SERVICES (VCS) TRANSITION	
PHE Telehealth Waiver or Flexibility	Effective May 11, 2023*
Allows online digital E/M services (CPT codes 99421-99423) to be provided to Medicare beneficiary by a qualified FQHC practitioner. Billed to Medicare under G0071.	Online digital E/M services will no longer be included as part of VCS and in the payment for G0071.
VCS are available to new patients not seen in the FQHC within the previous 12 months.	VCS (G2010 and G2012) are available to established FQHC patients.
Consent for VCS may be obtained at the time services are furnished, but prior to being billing.	Consent for VCS (G2010 and G2012) must be obtained prior to rendering services.
Consent for VCS may be obtained under general supervision.	Consent for VCS (G2010 and G2012) must be obtained under direct supervision.

**End of business day on May 11, 2023*

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.

Only those core practitioners who are qualified by license and scope of practice to furnish E/M services may provide VCS.

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

© 2020 National Association of Community Health Centers. All rights reserved. | QualityCenter@nachc.org | May 2023

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.

The American Medical Association (AMA) provides the following definitions of online digital E/M services in the CPT Manual.

- **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.
- **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.

During the PHE, 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). Following the end of the PHE, the rate will be based upon the average of G2010 and G2012, which means CMS may change the 2023 payment rate for G0071.

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/ Medicare 2023 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	$23.72*
CPT 99421 99422 99423	Online digital evaluation and management services, for an established patient, for up to 7 days.*	G0071	$23.72

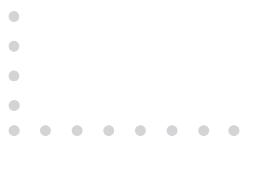
Note: Rates here are based on the 2023 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending upon the GAF/GPCI.

**Digital assessment services are payable for services furnished up through May 11, 2023.*

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), 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.

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 and was new for 2019.
- CMS CY 2023 Medicare Physician Fee Schedule Final Rule. https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf
- CMS FQHC Flexibilities and End of PHE Transition. https://www.cms.gov/files/document/rural-health-clinics-and-federally-qualified-health-centers-cms-flexibilities-fight-covid-19.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
- CMS Medicare Learning Network. New & Expanded Flexibilities for FQHCs during the COVID-19 PHE. https://www.cms.gov/files/document/se20016-new-expanded-flexibilities-rhcs-fqhcs-during-covid-19-phe.pdf
- CMS. Virtual Communication Services FAQ’s. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.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



© 2020 National Association of Community Health Centers. All rights reserved.