



# 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. These services must exceed five (5) minutes in duration 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).

VCS must be initiated by the patient (i.e., via telephone, online, sending an audio or visual message/image). The provider’s response can be by telephone audio/video, secure text messaging, email or through a 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 and are paid at the same rate as if the patient came in to the FQHC for a visit.



## Patient Eligibility & Consent

Patients initiate the use of VCS through communication to a provider for evaluation and interpretation of their condition.

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

HCCPS 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.

### 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.”



## Initiating Visit

To bill for VCS, patients must have been seen in the health center within the previous year. The billing provider does not need to be a provider that the patient has seen previously.



## 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<br>or<br>DO              | Non-Physician Practitioners |    |     |     |                           |                                     |
|                             | NP                          | PA | CNM | CNS | Clinical<br>Psychologists | Licensed Clinical<br>Social Workers |
| X                           | 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.



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### 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.

Document 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.

- **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.

| WHAT PROVIDER CODES     | Services  | What FQHC bills to CMS | CMS/Medicare 2020 Fees |
|-------------------------|---|------------------------|------------------------|
| <b>G2010/<br/>G2012</b> | 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                  | \$24.75*               |

*\*Claims submitted with G0071 on/after March 1, and for the duration of the PHE, will be paid at this new rate instead of the 2020 FFS rate of \$13.53.*

*Note: Rates here are based on the 2020 Medicare Physician Fee Schedule (PFS); not 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.*

G0071 requires FQHC providers to document at least five minutes of time spent by eligible providers (i.e., MD, DO, NP, PA, CNM, psychologist, and LCSW). Therefore, despite G2010 and G2012 having different time requirements, a minimum of five minutes must be documented for a FQHC to bill G0071.

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](#) 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>.
- Communication Technology Based Services and Payment for Rural Health Clinics (RHCs) and Federal Qualified Health Centers (FQHCs). CMS. Medicare Learning Network. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10843.pdf>