New Code for Virtual Check-Ins:
- G2012, Brief communication technology-based service, established patient, not originating from a related E/M service (5-10 minutes)
- Payable effective Jan. 1, 2019
- Coding requirements generally similar to 99441 (Telephone E/M)

Regulatory Rationale:
- Part of CMS’ ongoing effort to modernize payments
  - Incentivize new primary care clinicians
  - Drive quality of care for chronic diseases, avoid hospitalizations
- Reflect changes in technology and clinical practice

Qualifying Technology:
- Real-time telephone audio or synchronous audio/video
- Privacy requirements still apply

<table>
<thead>
<tr>
<th>QUALIFIES</th>
<th>DOES NOT QUALIFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/VUMC telephone</td>
<td>MHAV/Patient Portals</td>
</tr>
<tr>
<td>Personal smart phone</td>
<td>Email</td>
</tr>
</tbody>
</table>

Consent:
- Check-ins must be patient-initiated
- Patient must specifically consent to each billing instance
- Consent documented in the virtual check-in note

Other Billing Requirements:
- Established patients only (follows same specialty/subspecialty rules)
- Can’t relate to an E/M service:
  - provided within the previous 7 days
  - resulting from the check-in within 1 day (or next available time)
- Time-based coding:
  - Clinician’s medical discussion time only; Excludes staff time
  - Do not double-count time with CCM
  - Document time in minutes as part of check-in note
- No frequency limitation, will monitor utilization