COVID-19 TOWN HALL Q&A – April 15, 2020

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MEMBER QUESTIONS	AAFP RESPONSES
TELEHEALTH	
What are the payment rules for telephone-only services?	Effective March 1, 2020, through the duration of the current public health emergency, the Centers for Medicare & Medicaid Services (CMS) added Medicare coverage of, and payment for, evaluation and management (E/M) services (99441-99443). These services may be provided for new or established patients. For more information, visit the AAFP COVID-19 telehealth page under the CMS Relaxes Regulatory Requirements header.
Can telehealth and virtual/digital services be provided to new Medicare patients?	Yes. Even though some of the code descriptors refer only to established patients, CMS is also allowing telehealth and virtual services to be provided to new patients for the duration of the current public health emergency.
Will Medicare pay telehealth visits at the same rate as in-person visits?	If you have a virtual visit with real-time video and audio, and you code it with the appropriate office visit CPT code (99201-99215) with a place of service (POS) you normally use for in-person visits (such as 11 - office) and append a -95 modifier, Medicare will pay for those services at the same rate as an in-person visit in the office.
Can I provide the Medicare annual wellness visit (AWV) service via telehealth?	The Medicare AWV codes are on the list of approved Medicare telehealth services. However, they were placed on the list when the originating site restrictions were in place, limiting Medicare coverage of telehealth services to clinical sites, such as physician offices. It is unclear that CMS anticipated Medicare AWV to be delivered via telehealth in non-clinical sites, such as a patient's home. It is also unclear how some elements of the visit (e.g., blood pressure, body mass index or waist circumference) would be accommodated and accepted by CMS as current guidelines require these to be obtained by a health professional. Absent explicit guidance from CMS on this issue, the AAFP does not advise doing a Medicare AWV via telehealth unless the patient is in a clinical originating site. Commercial and private payers may have different policies. Please check with your local provider representative for additional guidance.
CONTINUING PROFESSIONAL DEVELOPMENT AND CONTINUING MEDICAL EDUCATION	
Are there links for the AAFP's Virtual Town Hall continuing medical education (CME) credit?	Provide feedback and submit for Live credit here. Provide feedback and submit for Enduring credit here. You will be required to sign in with your AAFP login.

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

ADVOCACY AND GOVERNMENT RELATIONS	
Can you summarize the Primary Care Marshall Plan and its impact on family physicians?	The best summary we can recommend of the Primary Care Marshall Plan and fixing the broken elements of our health care system can be found in an April 14 entry to the In The Trenches blog.
Health disparities are occurring with COVID-19 treatment and those contracting the virus. How can we better advocate for our community?	Health disparities associated with COVID-19 are complex. To date, the AAFP has supported better data collection, funding for programs that ensure basic access and policies to increase primary care access. For example, the AAFP is supporting a joint letter urging more data collection on how COVID-19 impacts racial minorities; the AAFP has urged Congress to support programs that address the needs of those with low-income status, such as providing community health center and Medicaid funding; and the AAFP is working to expand the number of no-cost primary care visits for those with high-deductible health plans and to advance more equitable health care distribution through the Teaching Health Center Graduate Medical Education program (THCGME).
Is the AAFP advocating for physicians to be paid by their National Provider Identifier (NPI) number?	The U.S. Department of Health and Human Services (HHS) is disbursing funds through the Coronavirus Aid, Relief and Economic Security (CARES) Act Provider Relief Fund in the same manner that CMS is already paying for services under the Medicare program. Just as Medicare payments go to the billing Tax Identification Number (TIN), rather than individual NPIs, so, too, are payments made under the CARES Act Provider Relief Fund. Using an existing payment mechanism facilitates disbursement of the fund, getting the money to health care entities more quickly than establishing a new, unique approach, such as paying individual physicians at the NPI level.
What is expected for the future of the CARES Act?	From a regulatory perspective, we anticipate CMS will soon release another interim final rule that responds to the COVID-19 public health emergency. This additional guidance will likely further clarify and expand temporarily relaxed regulations. From a congressional perspective, the AAFP will call for passage of the Primary Care Patient Protection Act, as well as more small business loans in the fourth supplemental package and more provider relief funding.
HEALTH OF THE PUBLIC AND SCIENCE	
How can a retired physician volunteer during the current public health emergency?	Opportunities and requirements vary from state to state. The AAFP recommends first contacting your state AAFP chapter, state medical society and state medical board. These are the best resources to connect you with volunteer efforts. The Federation of State Medical Boards has information you may find helpful, including: • States that have waived or modified their licensure requirements for physicians to practice across state lines. • States that welcome retired and inactive physicians. AAFP members may also register with Heart to Heart International (HHI), which has activated its volunteer roster of health care professionals and is working with International Medical Corps to provide medical surge capacity to hospitals around the United States to fill critical gaps in patient care,

	nursing and infection prevention and control. More detailed information on HHI is available here. Additional information for retired physicians from the AAFP can be found here.
PRACTICE ADVANCEMENT	
Do federally qualified health centers (FQHCs) and rural health clinics (RHCs) receive Medicare payment through the CARES Act?	The CARES Act allows FQHCs and RHCs to serve as distant site providers. CMS has not released any further billing and coding guidance on this yet. FQHCs and RHCs can bill for virtual communication services, which are like the e-visit and virtual check-in services available in fee-for-service (FFS) payment. The payment rate can be set by the secretary of HHS or it can be comparable to the telehealth rates paid under FFS. Information on the payment rate has not been released yet.
Are the six-month payments for the Small Business Administration (SBA) Debt Relief program's micro-loans deferred or are they structured like a grant?	The SBA Debt Relief Program will provide immediate debt relief to small businesses with **non-disaster** SBA loans, (e.g., 7(a), 504 and microloans). SBA will cover all loan payments on these loans, including principal, interest and fees for six months. New borrowers are eligible for this relief if they take out loans within six months of the president signing the law. This program is separate from the disaster relief loans.
What funds are available to employed physicians?	There are two programs that employed physicians may want to discuss with their employers to see how the employer intends to use the money to support family medicine practices. Funds disbursed to your organization under these programs are not made directly to physicians. First, the CARES Act Provider Relief Fund provides disbursement of funds based on 2019 Medicare Part B FFS claims. All payments are made to the billing organization according to its TIN. Second, the Medicare Advance Payment Program provides advances that are requested for each NPI. Again, payments are disbursed to the billing organization according to its TIN.
Which practices will receive payments from the CARES Act Provider Relief Fund?	Practices that billed Medicare in the fourth quarter of 2019 should receive a payment from the CARES Act Provider Relief Fund. Again, payments are made to the TIN, not at the NPI level.
What should I do if I have not received any funds in my back account from these programs? Is this HHS verifying bank information?	The AAFP recommends reaching out to your Medicare Administrative Contractor (MAC) or to HHS for confirmation.
Are there parity rates between facility and non-facility services?	Prior to the COVID-19 pandemic, Medicare paid telehealth services at the facility rate, which is typically lower than the non-facility rate. CMS has temporarily revised this policy and will pay telehealth visits at the non-facility rate. To receive this rate, physicians should use the POS they would have used if the service had been provided in-person (e.g., POS 11 -

	Office). Physicians will also need to append the -95 modifier to the claim line delivered via telehealth. Service billed with POS 02 - Telehealth will be paid at the standard telehealth rate. Most private payers are mirroring CMS' parity policy. In general, they are also requiring the POS where the physician typically provides services. The required modifiers vary. It is best to check with your local provider representative to verify their policy and billing and coding requirements. The AAFP is advocating for consistent requirements across all payers.
Is Medicare also covering E/M codes 99213-99215 for audio-only services?	No. Medicare currently requires real-time audio and video to report office/outpatient E/M codes, such as 99213-99215 as telehealth services.
Is Medicare covering audio-only services for FQHC's?	Medicare covers Virtual Communication Services for FQHCs/RHCs via HCPCS code G0071. Virtual Communication Services include brief non-face-to-face communication (e.g., telephone) between the FQHC/RHC provider and FQHC/RHC patient. This can be a new or established patient. CMS has not issued guidance on whether FQHCs/RHCs can provide and receive payment for telephone E/M services (CPT 99441-99443).
Do time-based codes include chart review, note writing, etc.?	Medicare is allowing the level of service for office/outpatient E/M services to be selected based on time, with time defined as all of the time associated with the E/M service on the day of the encounter.
Is the telehealth POS code 02?	Not for Medicare. If you are billing for 99201-99215 office visit, use your normal place of service as you would for a face-to-face visit and then use a -95 modifier. This will ensure you get paid at the in-person encounter rate, not the telehealth rate.
Is CMS distinguishing E/M telehealth services for new and established patients? Will they reject an E/M code for a new telehealth patient?	No. As noted above, even though some of the code descriptors refer only to established patients, CMS is allowing them to be provided to new patients as well for the duration of the current public health emergency.
Should we charge co-pays and deductibles?	The Families First Coronavirus Response Act (FFCRA) waives cost-sharing for COVID-19 testing-related services for Medicare Part B patients. Cost-sharing is waived for office visits that result in the order or administration of the COVID-19 test, or the evaluation of an individual to determine the need for such a test. The cost-sharing waiver is effective for dates of service starting March 18, 2020, until the end of the current public health emergency. Physicians should use the -CS modifier on applicable claims to identify the service subject to the cost-sharing waiver. Medicare beneficiaries should not be charged for any co-insurance or deductible for those services. The -CS modifier will signal the MACs to pay 100% of the allowable cost for the service. Physicians should contact their MAC and request to resubmit applicable claims with dates of service on or after March 18, 2020, that were submitted without the -CS modifier. The -CS modifier should not be used for services unrelated to COVID-19.

	Please check with your commercial payers regarding how they are handling cost-sharing for COVID-19-related services for their members.
Are co-pays being waived? Is this just considered a loss for us or should we be billing this?	It depends. As noted above, the waiver of Medicare beneficiary cost-sharing via use of the -CS modifier should not result in a loss for the practice since Medicare will pay 100% of the allowed amount for those services. Ideally, commercial payers who waive cost-sharing for their members should also be paying 100% of the allowed amount for the services in question. Please confirm this with your commercial payers. If a practice voluntarily waives patient cost-sharing in other, individual circumstances (e.g., patient indigency), then that may be a loss to the practice.
Are Medicare annual wellness visits on the list of approved Medicare telehealth services?	The Medicare AWV codes are on the list of approved Medicare telehealth services. However, they were placed on the list when the originating site restrictions were in place, limiting Medicare coverage of telehealth services to clinical sites, such as physician offices. It is unclear that CMS anticipated Medicare AWV to be delivered via telehealth in non-clinical sites, such as a patient's home. It is also unclear how some elements of the visit (e.g., blood pressure, body mass index or waist circumference) would be accommodated and accepted by CMS as current guidelines require these to be obtained by a health professional. Absent explicit guidance from CMS on this issue, the AAFP does not advise doing a Medicare AWV via telehealth unless the patient is in a clinical originating site. Commercial and private payers may have different policies. Please check with your local provider representative for additional guidance.

What can you tell us about COVID-19 antibody testing?	Family physicians that have a Clinical Laboratory Improvement Amendments (CLIA) license of high or moderate complexity have three options for antibody testing. There are now four antibody tests that have FDA Emergency Use Authorization (EUA). They are:
	• Cellex Inc.
	  ○ qSARS-CoV-2 IgG/IgM Rapid Test
	• Ortho-Clinical Diagnostics, Inc.
	  ○ VITROS Immunodiagnostic Products Anti-SARS-CoV-2 Total Reagent Pack
	• Chembio Diagnostic System, Inc.
	  ○ DPP COVID-19 IgM/IgG System
	• Mount Sinai Laboratory
	  ○ COVID-19 ELISA IgG Antibody Test
	
	At this point, there are no serological tests that are considered waived.

Where can I find a list of Medicare Administrative Contractors (MACs)?	The AAFP has built a table with a list of MACs here.
Are there waivers for nurse practitioners (NPs) working in nursing homes so they can provide care to face-to-face new admits? Can they perform all the services that a physician is expected to do?	Yes. CMS is providing relief to long-term care facilities related to provision of physician services through the following actions: • For physician delegation of tasks in skilled-nursing facilities (SNFs), CMS is waiving the requirement that prevents a physician from delegating a task when the regulations specify that the physician must perform it personally. This waiver gives physicians the ability to delegate any tasks to a physician assistant, nurse practitioner or clinical nurse specialist who meets the applicable definition in 42 C.F.R. 491.2, or in the case of a clinical nurse specialist, is licensed as such by the state and is acting within the scope of practice laws as defined by state law. CMS is temporarily modifying this regulation to specify that any task delegated under this waiver must continue to be under the supervision of the physician. This waiver does not include the provision that prohibits a physician from delegating a task when the delegation is prohibited under state law or by the facility's own policy. • For physician visits, CMS is waiving the requirement that all required physician visits (not already exempted in § 483.30(c)(4)) must be made by the physician personally. CMS is modifying this provision to permit physicians to delegate any required physician visit to a nurse practitioner (NPs), physician assistant or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician and who is licensed by the state and performing within the state's scope of practice laws. The NP must still have physician supervision, but NPs can do an initial visit, and that visit doesn't have to be in person. It can be via telehealth.
Is there relief for hospital-employed family physicians who are faced with loss of income due to contract agreements, such as work relative value unit (RVU) and Medicare Advantage reimbursements based on quality matrix?	The AAFP is not aware of any such relief. Employed family physicians will need to approach their employers about relief from any contractual provisions that are negatively impacting them or their practice. Most of the relief granted by CMS to date is limited to traditional Medicare. CMS generally does not dictate how Medicare Advantage plans compensate physicians in their respective networks. As with commercial health plans, physicians will need to approach the Medicare Advantage plans with whom they contract for relief from those contracts.
Can transitional care management (TCM) visits be conducted through a virtual or phone visit?	Per CPT coding, TCM codes 99495 and 99496 include one face-to-face visit (but not necessarily in-person) that is not separately reportable. CMS has not specifically addressed this question. However, the AAFP is not aware of any reason the visit included in the TCM codes could not be done as a telehealth visit using real-time audio and visual technology since CMS is otherwise covering such visits as stand-alone services. To date, CMS is not considering a phone (audio-only) visit equivalent to a telehealth visit involving audio and visual technology. Given that CPT coding describes the visit included in TCM as "face-to-face," we would not advise doing that visit as a telephone (audio-only) visit.

Will telehealth visits conducted currently not be audited?	HHS and the Office of the Inspector General (OIG) have provided guidance that they would relax some enforcement, but we don't know that there would be no audits.
Is the Comprehensive Primary Care Plus (CPC+) program affected by the changes coming from CMS?	At this time, the Center for Medicare and Medicaid Innovation (CMMI) has not announced any updates or changes to this program. The AAFP is monitoring this closely.
Why aren't physicians getting relief payments individually?	All relief payments under the CARES Act Provider Relief Fund are being made to Medicare providers and suppliers according to their TIN rather than the individual's NPI. Accordingly, employed physicians should not expect to receive an individual payment directly. The employer organization will receive the relief payment as the billing organization. Likewise, individual physicians and providers in a group practice are unlikely to receive individual payments directly, as the group practice will receive the relief fund payment as the billing organization. Physicians in group practices should look to the part of their organization that bills Medicare to identify details on Medicare payments for 2019 or to identify the accounts where they should expect relief payments. Solo physicians who bill Medicare will receive a payment under the TIN used to bill Medicare.
Should the co-pay be waived when screening for COVID-19, or only testing?	The Families First Coronavirus Response Act (FFCRA) waives cost-sharing for COVID-19 testing-related services for Medicare Part B patients. Cost-sharing is waived for office visits that result in the order or administration of the COVID-19 test **or** the evaluation of an individual to determine the need for such a test. The cost-sharing waiver is effective for dates of service starting March 18, 2020, until the end of the current public health emergency.
Some visits may start as telehealth, but when patients can't access their cameras, microphone, etc., the visit becomes an audio/phone-only visit. Is there a difference in the reimbursement?	CMS states that it depends on whether the service was "rendered" with video. The AAFP's interpretation of this is that if you were able to complete the medical service while the video was working, you would be able to bill the appropriate 99201-99215 code even if the entire visit (e.g., the video cut out while you were giving instructions to the patient and you had to finish the instructions via audio only) did not have video. If you conducted the care during the audio-only portion, then you would need to code it as a telephone-only visit (99441-99443). For your specific scenario, you would bill it as a telephone-only visit.
How would we know if our NPI was used to apply for Medicare advance payments? Does this create any personal liability or responsibility on our part?	Employed physicians and those in group practices should look to the part of their organization that bills Medicare to identify details on Medicare payments for 2019 and how those relief funds will be used to support primary care.
What is payment for code 99441-99443?	The Medicare national non-facility payment rates for telephone E/M services are: • 99441 - $14.44 • 99442 - $28.15 • 99443 - $41.14

Are RHC telehealth visits reimbursed at the RHC rate or E/M rate?	Telehealth visits will not be paid at the FQHC prospective payment system (PPS) or RHC all-inclusive rate (AIR) payment rates. They will be paid at an amount set by the secretary of HHS or a rate comparable to FFS. CMS has not released any information on these rates yet.
Our TIN is the same as the hospital. Will I qualify for the two relief programs that are intended for businesses with 500 or fewer employees?	There are common terms you should be familiar with to help ensure that a business is correctly classified as a small business. One such term is affiliates. You must include the employees or receipts of all affiliates when determining the size of a business. Affiliation with another business is based on the power to control, whether exercised or not. The power to control exists when an external party has 50% or more ownership. It may also exist with considerably less than 50% ownership by contractual arrangement or when one or more parties own a large share compared to other parties. Check the SBA's compliance guide for size and affiliation for more detailed information. Based on this definition, it appears your office would be affiliated with the hospital. If so, the number of employees in the TIN would need to be 500 or fewer for you to be eligible for the small business loans. You can find more information on size standards on the SBA's website here. Discuss your individual situation and verify this with your lender.
Is there any reporting relief due to COVID-19 for the Merit-based Incentive Program (MIPS)/Quality Payment Program??	CMS has extended the deadline for submitting MIPS data to April 30, 2020. Additionally, CMS is extending the deadline to apply for re-weighting the quality, cost and improvement activities performance categories based on extreme and uncontrollable circumstances and the promoting interoperability performance category based on extreme and uncontrollable circumstances to April 30, 2020, or a later date that CMS may specify. CMS is also creating an exception for the 2019 performance period/2021 MIPS payment year only, such that if a MIPS-eligible clinician demonstrates through an application submitted to CMS that they have been adversely affected by the current public health emergency, but also submits data for the quality, cost or improvement activities performance categories, the performance categories for which data are submitted would still be re-weighted (subject to CMS' approval of the application). The data submission would not effectively void the application for re-weighting. CMS is also modifying its policy to create a similar exception for the promoting interoperability performance category for the 2019 performance period/2021 MIPS payment year only.
My health system received several large loans at low-interest rates, yet they are still furloughing staff. Can they do this?	Yes. There are several low-interest rate loans available that may be used for expenses other than payroll. The amount of the loan forgiveness for some of these loans (e.g., Paycheck Protection Program) may be reduced if either the full-time equivalent employees or their salaries and wages have not been maintained.