COVID-19 TOWN HALL Q&A – April 22, 2020

QUESTION TOPIC INDEX

- **Telehealth**
- **Advocacy and Government Relations**
- **Health of the Public and Science**
- **Practice Advancement**

MEMBER QUESTIONS	AAFP RESPONSES
TELEHEALTH	
There seems to still be confusion about performing the Medicare annual wellness visit (AWV) via telehealth. Can I provide this service via telehealth?	The AAFP is aware there remains confusion about providing the Medicare AWV via telehealth. It is unclear that the Centers for Medicare and Medicaid Services (CMS) anticipated the 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. On a recent CMS Open Door Forum, the agency acknowledged that there is confusion about the service, but they stopped short of saying they believe it could be delivered when the patient's home is serving as the originating site. We're continuing to seek clarity from CMS on this issue. Commercial and private payers may have different policies. Please check with your local provider representative for additional guidance.
Can the AAFP recommend a reasonable time frame for each telehealth encounter?	Telehealth services are too variable to be able to state a reasonable versus unreasonable time frame. Time for each visit will vary based on patient need. If you are using video, and therefore can bill for an office visit, then you could use your usual appointment time intervals. If you are providing an audio-only service and can only bill the telephone codes (99441-99443), which are time-based, then you could use those as a guide and direct patients that the calls are limited (i.e., 99441 = 5-10 minutes, 99442 = 11-20 minutes, 99443 = 20+ minutes). CMS is allowing physicians to select the level of office visit evaluation and management (E/M) service delivered via telehealth using either time or medical decision-making. They are defining time as all time spent on the day of the encounter. When selecting the E/M level based on time, physicians should use the 2020 typical times. When selecting based on medical decision-making, physicians should use the current medical decision-making criteria.

What are the AAFP's thoughts on the future of telehealth visits?	The AAFP continues to advocate that the recent expansion of telehealth in primary care be continued beyond the COVID-19 pandemic. There are significant value-added benefits to be gained, such as improved patient access to a family physician, patient convenience, more intensive chronic disease management and the ability to expand physicians' capacity to care for patients. Telehealth can be a valuable asset in a value-based care environment.
Does the AAFP believe telehealth reimbursement will be extended if a second wave of COVID-19 cases extends into the summer?	Some of the current telehealth payment policies predate the current public health emergency, and thus are likely to continue when the current emergency ends and into any subsequent wave(s) of COVID-19 cases. However, other telehealth payment policies have been implemented specifically for the duration of the current public health emergency. Whether public or private payers will extend them beyond that is unknown. The AAFP is watching this closely.
Will AWVs conducted via telehealth be reimbursed if patients provide their vitals?	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 AWVs 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. We are continuing to seek clarity from CMS on this issue. Commercial and private payers may have different policies. Please check with your local provider representative for additional guidance.
Are transitional care visits covered if they are audiovisual or audio/phone visits?	Per Current Procedural Terminology (CPT), transitional care management (TCM) codes 99495 and 99496 include one face-to-face (but not necessarily in-person) visit that is not separately reportable. CMS has not specifically addressed this question. However, we know of no reason the visit included in the TCM codes could not be done as a telehealth visit using real-time audiovisual 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 describes the visit included in TCM as "face-to-face," we would not advise doing that visit as a telephone (audio-only) visit.

What should physicians do about the visual acuity screening and electrocardiogram (EKG) screening required at the "Welcome to Medicare" preventive visit?	Like the AWV, CMS has not issued any guidance on the "Welcome to Medicare" visit, also known as the initial preventive physical examination (IPPE).
Can the AAFP provide more information about billing a time-related telephone visit or a regular E/M code when doing a thorough review of diabetes mellitus, hypertension, gastroesophageal reflux disease and lipids all in one phone visit?	Select the appropriate level of E/M services based on the following: • Level of medical decision-making as defined for each service or • Total time for E/M services performed on the date of the encounter. When time is used to select the appropriate level for E/M codes, time is defined by the service (CPT code) descriptors as typical time (using the 2020 CPT code descriptors). Use 2021 guidelines for calculating total time: Time should be based on the total time spent in the care of the patient on the date of the encounter. Total time includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (including time in activities that require the physician or other qualified health care professional, but not including time in activities normally performed by clinical staff). Physician/other qualified health care professional time includes the following activities: • Preparing to see the patient (e.g., review of tests) • Obtaining and/or reviewing separately obtained history • Performing a medically appropriate examination and/or evaluation via audio or audiovisual technology • Counseling and educating the patient, family or caregiver • Ordering medications, tests or procedures • Referring and communicating with other health care professionals (when not separately reported) • Documenting clinical information in the electronic or other health record • Independently interpreting results (not separately reported) and communicating results to the patient, family or caregiver • Care coordination (not separately reported) The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of a separate, distinctly identifiable signed written report may also be reported separately using the appropriate CPT code and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service but is not separately reported, it is part of the medical decision-making.

	Total time spent in care of the patient on the date of the encounter should be clearly documented in the patient's electronic health record (EHR).
What CPT code is used for a telephone visit? Is it 99213 or does that require video?	Medicare covers telephone visits through Healthcare Common Procedure Coding System (HCPCS) code G2012 and CPT codes 99441-99443. Medicare requires audio-video for office visit E/M services (99201-99205, 99211-99215) delivered via telehealth. United Healthcare and Humana have indicated they will cover office visit E/M services delivered via audio only. Those encounters should be billed the same as an audio-video visit. Most other private payers will accept CPT codes 99441-99443. It is best to check with your provider relations representatives to verify their policies.
ADVOCACY AND GOVERNMENT RELATIONS	
Is the Coronavirus Aid, Relief and Economic Security (CARES) Act for family physicians?	Yes. There are several provisions in the CARES Act that can apply to physicians. There are small business loan programs, as well as a grant that some physicians are qualified to apply for. In addition, it contains provisions that address telehealth coverage policies. Learn more at the AAFP's COVID-19 Financial Relief for Family Physicians webpage.
Is the CARES Act different from disaster grants and the Paycheck Protection Program (PPP) for small business?	The CARES Act was a piece of legislation that provided supplemental funding for many different programs, including loan programs, such as the PPP and the Economic Injury Disaster Loan assistance, as well as a Provider Relief Fund intended to issue grants to health care entities and their workforce. Learn more at the AAFP's COVID-19 Financial Relief for Family Physicians webpage.
What is the AAFP doing about scope of practice legislation regarding non-physician providers (i.e., physician assistants, nurse practitioners, etc.)?	On March 24, 2020, the Department of Health and Human Services (HHS) Secretary Alex Azar sent a letter to governors asking for their assistance to extend the capacity of the health care workforce to address the pandemic. Specifically, Azar called for immediate action on eight recommendations that would waive restrictions on licensure, scope of practice, certification, recertification and relicensure. The letter points to "temporary" adjustments to existing regulations. This language is sufficient to prevent permanent, national standards from being adopted at the present time. It does create a challenging precedent, but it stops short of a national standard or waiver. Most state legislatures have suspended sessions or adjourned early due to COVID-19. The AAFP Center for State Policy is unaware of any scope legislation moving through legislatures at this time. However, the center continues to work with our constituent chapters to ensure that physicians lead patient

	care, and the AAFP will continue to advocate for policies and guidelines that protect the scope of family medicine. The AAFP has long communicated that all health care professionals share an important role in providing care to patients. However, their skills are not interchangeable with those of a fully trained physician, and this is especially true in family medicine and primary care. Visit the Center for State Policy webpage to view the scope of practice advocacy resources available to members and chapters.
Are the HHS funds being given to physicians to supplement the "waived" co-pays, which we do not collect while doing telehealth?	The AAFP called the HHS CARES Provider Relief hotline (866-569-3522) on April 23, 2020, and spoke to "Odessa." We asked this question and were informed that physicians are allowed to use the funds to cover co-pays, which are not collected when doing telehealth, unless they are otherwise being reimbursed. The reference number for the call is D01141342487935. Please keep this reference number with your documentation for use of funds. Odessa encouraged anyone with a question to call that number for assistance. As background, the terms and conditions of the HHS relief fund payments state that the provider will only be reimbursed for health care related expenses or lost revenue attributed to COVID-19 and the funds will not be used to reimburse expenses or losses reimbursed by other sources. HHS has determined that every patient is a possible case of COVID-19, and that care not specifically related to COVID-19 can cause health care-related expenses attributed to COVID-19. However, the CARES Act does not define "lost revenues that are attributed to coronavirus." As written, the terms would include lost revenues due to replacing in-person visits with telehealth services. We will continue to monitor any additional guidance. Providers should be prepared to estimate lost revenues and lost operating margins. Physicians should document and track how funds are used by individual physicians, as use of funds will be audited in the future.
What is the AAFP doing to advocate that payers extend reimbursement for telehealth visits?	As part of the AAFP's private payer advocacy agenda, we are urging payers to continue to allow in-network physicians to provide telehealth to their patients beyond the COVID-19 pandemic. The AAFP is also advocating that payers pay these visits the same as in-person visits (parity).
HEALTH OF THE PUBLIC AND SCIENCE	
What personal protective equipment (PPE) should a physician wear? We don't have point-of-care COVID-19	The following is Centers for Disease Control and Prevention (CDC) guidance on prevention measures for the spread of COVID-19:

tests, but we need to see a patient face-to-face.	Ensure rapid, safe triage and isolation of patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough).
	• Ensure that triage personnel who will be taking vitals and assessing patients wear a respirator (or facemask if respirators are not available), eye protection and gloves for the primary evaluation of all patients presenting for care until COVID-19 is deemed unlikely.
	• Triage personnel should have a supply of facemasks or cloth face coverings. These should be provided to all patients who are not wearing their own cloth face covering at check-in, assuming a sufficient supply exists.
	• Isolate patients with symptoms of COVID-19 in an examination room with the door closed. If an examination room is not readily available, ensure the patient is not allowed to wait among other patients seeking care.
	  ○ Identify a separate, well-ventilated space that allows waiting patients to be separated by six or more feet, with easy access to respiratory hygiene supplies.
	  ○ In some settings, patients might opt to wait in a personal vehicle or outside the health care facility, where they can be contacted by mobile phone when it is their turn to be evaluated.

What role does the AAFP see family physicians playing in the next stage of the pandemic?	The AAFP believes we are already entering the next stage of the pandemic. Family physicians must continue to play an important role by providing frontline care for both inpatient and outpatient services, as well as leadership for recovery and rebuilding with primary care as foundational for an improved and better-integrated health system.
Can family physicians do wellness exams without doing a physical exam?	Wellness visits (CPT codes 99381-99387 and 99391-99397) are not currently on Medicare's list of covered telehealth services. Coverage will differ by private payer. You will need to check with your provider relations representative to verify their policies.
What are "COVID toes"?	While "COVID toes" are not yet a confirmed symptom of COVID-19, there seems to be a correlation between toe lesions and SARS-CoV-2 infections. The lesions are purple and typically appear around the tips of the toes, though they usually heal without leaving marks on the skin. It is still unclear why this is happening, but it may be due to inflammation caused by the virus.
Is it advisable to have a pulse oximeter handy to assess the progress of COVID-19 in an individual?	Per the National Institutes of Health (NIH) and CDC guidelines: For adults with COVID-19 who are receiving supplemental oxygen or who are living in skilled nursing facilities, close monitoring with pulse oximetry is recommended. Screening for COVID-19 using pulse oximetry has not been recommended to date.

<table>
<tr><th colspan="2">PRACTICE ADVANCEMENT</th></tr>
<tr><td>For providers who practice in one state (Massachusetts), but have some patients who live or work in another state (Rhode Island), do you document the patient's mailing address or where they are during the time of the telehealth visit? Do you need to be licensed in the state they reside in or where they are during the visit?</td><td>You should contact your Medicare Administrative Contractor (MAC). Contact information for the MAC for Massachusetts and Rhode Island is below. Here is a reference for state licensure requirements from the Federation of State Medical Boards.
<table>
<tr><th>State/Region</th><th>Live Representative (toll-free number)</th><th>IVR</th><th>PCC Hours of Service</th></tr>
<tr><td>Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont</td><td>866-837-0241
TTY: 866-786-7155</td><td>877-869-6504</td><td>Monday-Friday*8 a.m.-4 p.m. ET
*Closed for training on the 2nd and 4th Friday of the month from 12-4 p.m. ET</td></tr>
</table></td></tr>
<tr><td>Many practices and health systems are facing the difficult decision of furloughing staff. What are recommendations to address the possibility of furloughing?</td><td>The AAFP has heard of possible furloughs. Government funds are coming through to assist hospitals, so we may start to see that soon. Hospitals might look at other possible ways to mitigate financial concerns by reducing bonuses or temporary reducing compensation. You can also be proactive by finding new revenue streams and creating new billable encounters.</td></tr>
<tr><td>In the event a volunteering physician is asked to care for non-COVID-19 patients due to illness of hospitalists, are they still released from liability under the CARES Act even for non-COVID-19 patients?</td><td>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 the 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.</td></tr>
<tr><td>Payers are still expecting patients to have a co-pay or the telehealth visit. Are offices expected to pay for the cost of telehealth visits?</td><td>Medicare and private payers are waiving cost-sharing for in-person and telehealth visits related to COVID-19 testing. These include office/outpatient services that result in the order or administration of the COVID-19 test, or services related to</td></tr>
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	the evaluation of a patient to determine the need for such a test. Medicare, Cigna and Humana will cover the cost-sharing (i.e., pay 100% of the allowable/contracted amount) for such encounters when the “CS” modifier is used. Other payers may have different coding guidelines. Medicare is allowing practices to waive cost-sharing for other visits, including virtual check-ins (HPCPCS code G2012) and e-visits (CPT codes 99421-99423). However, they will not cover the cost-sharing. Some private payers will waive and cover cost-sharing for telehealth services not related to COVID-19. However, self-funded plans may opt out of such waivers. Additionally, Medicaid policies are made at the state level. You will need to check with your provider relations representative to verify their policies.
Does the AAFP know if the redeployed physicians who had been working ambulatory were given any support to help them begin providing patient care?	The AAFP has not heard directly from redeployed physicians to know if they are being given the support they need. We encourage any physician in this situation to advocate for the training and support they feel they need to provide safe, high-quality patient care. They AAFP is offering CME courses to help support redeployed family physicians. Those courses can be found here.