COVID-19 TOWN HALL Q&A – March 25, 2020

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MEMBER QUESTIONS	AAFP RESPONSES
TELEHEALTH	
Is there a special code to use when a phone visit lasts over 10 minutes?	As of March 26, physicians and mid-level providers can bill for a Virtual Check-in (G2012) under Medicare for communications lasting 5-10 minutes. More info on Virtual Check-in is available on the AAFP's COVID-19 Telehealth page. Medicare is not currently paying for the phone-only evaluation and management (E/M) codes in CPT (i.e. codes 99441-99443). The AAFP has asked the Centers for Medicare & Medicaid Services (CMS) to take the appropriate actions to classify codes 99441, 99442, and 99443 as covered services in the Medicare program, and that CMS begin allowing physicians to bill for these services and that CMS issue payment for these services when billed by physicians.
Do you need a modifier for telephone-only telehealth calls?	Since CMS does not recognize telephone-only calls (without video) as a Medicare "Telehealth Service," a phone-only call is billed as a Virtual Check-In (G2012) with Place of Service - 11 (if you normally provide services from the office). No modifier is needed. It will vary for private payers. Please check with your local provider representative.
Do telehealth appointments always need to be done from the office or can they be done from the provider's home as well?	Telemedicine services can be delivered by the physician at home or other location.
How do you document a telehealth visit?	Telemedicine visits reported with traditional office visit E/M codes (e.g., 99201-99215) should be documented in the same way as when those services are provided in the office. In addition, note the service was done via telemedicine and any other details rather than as an in-person encounter. Other types of telehealth visits may require other types of documentation, depending on the service in question. For instance, G2012 (Virtual Check-in) is a time-based code, necessitating documentation of the time spent on the phone with the patient, in addition to the content of conversation.

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Can you conduct an annual wellness visit (AWV) via a telehealth appointment?	The Medicare AWV codes are on the list of approved Medicare telemedicine services. However, they were placed on the list when the originating site restrictions were in place, limiting Medicare coverage of telemedicine services to clinical sites, such as physician offices. It is unclear that CMS anticipated Medicare AWV to be delivered via telemedicine in non-clinical sites, such as a patient's home. It is also unclear how some elements of the visit (e.g., measurement of height, weight, blood pressure) would be accommodated and accepted by CMS. Absent explicit guidance from CMS on this issue, the AAFP does not advise doing a Medicare AWV via telemedicine unless the patient is in a clinical originating site.
Can family physicians conduct a critical care management (CCM) visit by phone?	Chronic care management services (CPT codes 99487-99491) are principally non-face-to-face services and already include telephone conversations with patients for whom the services are billed. The time spent on CCM-related phone calls with patients should be counted toward the time required to bill the appropriate CCM code(s).
Which mobile applications (apps) are recommended by the AAFP for telehealth visits? And does the patient need the app?	Patients do need to have the app. Some apps can run within a web browser. Unfortunately, there is no best app. There are several apps on the market. The AAFP's COVID-19 Telehealth page lists some apps members have been using. Due to the relaxing of Health Insurance Portability and Accountability Act (HIPAA) enforcement during the public health emergency, you can use non-HIPAA compliant consumer-level apps like Skype, Google Hangouts, FaceTime, etc.
Can family physicians bill group visits as a telehealth visit?	Yes, if the code(s) used to report the group visit are covered as telemedicine services by the payer in question and the payer otherwise covers group visits done in person.
What is the difference for telehealth with video/audio and the online digital evaluation?	Online digital E/M services (e.g., CPT codes 99421-99423) typically represent asynchronous telehealth services that the patient initiates through HIPAA-compliant secure platforms, such as electronic health record (EHR) portals, secure email, or other digital applications that allow digital communication with the physician or other qualified health professional. These services span seven days and do not typically include the synchronous face-to-face video component associated with telehealth with video and audio.

How do you code for a patient who is determined during the telemedicine visit to need a face-to-face office visit? Would you just code the face-to-face visit as an office visit?	Yes, if you provide a face-to-face visit the same day as the virtual visit, you can only bill for the face-to-face visit. Also, some visits requiring telemedicine codes cannot be a result of a face-to-face visit within seven days of the telemedicine visit.
Is it correct to use G2012 for all telephone visits?	As of March 26, that is correct for Medicare. Some private payers are paying for additional telephone-only codes. The AAFP is advocating for payment for telephone-only visits beyond just G2012. The AAFP is hearing that in some instances, practices are documenting with the E/M code, adding a modifier (i.e., Phone, Tel), and its billing department is fixing it on the back end. The practice has apparently decided to simplify reporting for its physicians and other clinical staff and empower and trust the billing staff to code correctly on the back end. There is nothing wrong with practices doing this internally if the claims submitted to third-party payers are filed with the correct codes and documentation supports the services reported on the claims. The AAFP recommends thorough documentation (i.e., method of contact, originating site, patient's site, and technology used. Ultimately, the physician is responsible for documentation and billing under his or her signature.
Telehealth reimbursement is being presented in the fee-for-service model. Are there any efforts to make it a capitated model so we can focus on care delivery and less on documentation?	The AAFP's Advanced Primary Care Alternative Payment Model (APC-APM) envisioned that most ambulatory E/M services, as well as non-face-to-face care management services, would be paid on a risk-adjusted per patient per month basis (i.e. capitated). Other value-based APMs also seek to move primary care away from traditional fee-for-service reimbursement. In general, the AAFP is supportive of APMs that move primary care away from fee-for-service.
Can the AAFP instruct the best way to code a telehealth visit for a Medicare patient?	Facility fees are for the originating site, so if you are having patients come to your clinic to have a telemedicine visit with a physician not in your practice at a distant site, then you could bill for a facility fee. CMS has more information on telehealth services here.
What are the stipulations for telemedicine visits for patients in a nursing home?	CMS states that "billing for Medicare telehealth services is limited to professionals. (Like other professional services, Critical Access Hospitals can report their telehealth services under CAH

	Method II). If a beneficiary is in a health care facility (even if the facility is not in a rural area or not in a health professional shortage area) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014. But the professional services can be paid for.”
Is code 99213 the correct billing code for a telemedicine visit?	That is correct if you are using live video AND your billing documentation has the Place of Service code of 02.
Is the AAFP doing anything to improve reimbursement for telemedicine visits?	The AAFP is continuing to advocate for appropriate payment for family physicians for telemedicine visits.
Are co-payments the same for telemedicine visits?	You can collect the appropriate co-payments for telemedicine services. You can also waive any copays if you wish, according to the Office of the Inspector General (OIG).
Is there a recommended telemedicine kit for physical therapy?	We have not heard from specific members, but that would be a great question for our communities of family physicians. Join the AAFP’s Telehealth Member Interest Group here or the COVID-19 Rapid Response Member Exchange here.
Can you briefly explain the difference between telemedicine and telehealth services?	Medicare and private payers are using the terms interchangeability. The AAFP has a short definition here and a long definition here. While we have specific definitions for both, during the pandemic many have been using telehealth as shorthand to mean both.
ADVOCACY AND GOVERNMENT RELATIONS	
Is there any guidance from CMS to capture Hierarchical Condition category (HCC) codes in these telehealth visits?	There has not been any CMS guidance on capturing HCC codes for telehealth visits to date, but the AAFP understands the burdens that exist. The AAFP has recommended technical solutions to CMS to address the administrative burdens associated with HCC coding and will educate members of any changes made for telehealth visits.
Has the AAFP conducted advocacy for medication assistance programs?	Medication assistance programs are operated by pharmaceutical manufacturing companies to provide patients with access to medication at a lower cost or at no cost. The AAFP has written to private and public payers to request flexibility during the current public health emergency and

	will continue to seek ways to increase access and reduce barriers to care in response to COVID-19. Please follow the AAFP's COVID resource pages for updates.
What are some of the other AAFP advocacy efforts during the public health emergency? Would you consider a Speak Out campaign encouraging members to contact their elected officials for telephone-only telemedicine reimbursement for Medicare patients?	On March 26, the AAFP sent a letter to CMS specifically calling for Medicare to reimburse for CPT codes 99441, 99442 and 99443 (telephone E/M visits). The AAFP has also called on commercial insurers to expand coverage and reimbursement for telehealth services.
As AAFP chapter leaders, are there any strategic steps we should take now on the local level to help promote telehealth reimbursement and parity?	States are taking legislative action to mitigate the effects of a COVID-19 outbreak. As states continue to debate legislation, the AAFP Center for State Policy has provided a backgrounder with state policy options that would be helpful to family physicians and the patients they serve. This backgrounder includes telemedicine policy solutions, including parity and reimbursement for specific codes. The center is working to develop a template letter chapters can use for advocating for telehealth policy changes at the state level.
Is the AAFP advocating for extension of nationwide social distancing?	On March 26, the AAFP and other organizations sent a letter to the Administration expressing continued support for travel and gathering restrictions to slow the transmission of COVID-19. The letter discussed that significant COVID-19 transmission has continued across the United States and asked for the administration to support science-based recommendations on social distancing that can slow the virus. The letter called for a strong nationwide plan that supports and enforces social distancing — and recognizes that our health and our economy are inextricably linked — and the practice should remain in place until public health and medical experts indicate it can be lifted. Finally, the letter discussed how federal, state and local governments should only set a date for lifting nationwide social distancing restrictions consistent with assessments by public health and medical experts.
HEALTH OF THE PUBLIC AND SCIENCE	
How should family physicians be treating adult and infant patients who need vaccines?	The AAFP developed guidance on COVID-19 Preventive and Non-urgent Primary Care visits on rescheduling and postponing care. It provides

	support to members making recommended practice changes during the COVID-19 pandemic.
PRACTICE ADVANCEMENT	
Can new patients be established via a telemedicine visit?	This depends on the service. Some telemedicine services (such as those reported with traditional office/outpatient visit codes 99201-99205 and Place of Service code 02) can be provided to new patients. Others (e.g., Virtual Check-in - G2012) are described as being just for established patients.
Do commercial payers also require Place of Service code 02 for billing?	Place of Service requirements will vary by carrier. Payer policies should be reviewed for applicable guidelines.
What is the status of residents and telemedicine billing?	The Accreditation Council for Graduate Medical Education (ACGME) is allowing residents to be involved in telehealth visits, following the rules related to direct (supervising physician monitoring, can be remote) and indirect (supervising physician immediately available, can be remote) supervision rules. The ACGME posted clarification of these rules here on March 20. For family medicine residents, programs should track each resident's type and quantity of visits to report in the annual ACGME WebAds Major Program Update section. Regarding Medicare billing, there has been no indication that CMS requirements for resident supervision and billing related to telemedicine visits otherwise differ from the requirements for in-person visits. In general, billing Medicare for services that involve residents reflects the involvement of the teaching physician, not the resident, since the services are typically billed to Medicare under the teaching physician's National Provider Identifier. Telehealth visits that meet Medicare coverage requirements are generally billed under the common office codes (e.g., codes 99213 and 99214), which means the same rules for resident supervision likely apply. Thus, telehealth visits billed at the 99213 level likely fall under the primary care exception rule, allowing for the supervising teaching physician to be immediately available (remotely), but not necessarily interacting with the patient during the visit. However, 99214 visits do not fall under the primary care exception and would likely require teaching physician interaction with the patient

	sometime during the visit. At this time, without information from CMS about resident supervision related to billing for other types of services (e.g., audio only [telephone], e-visits), the safest assumption is that billing can only be done to the extent that the teaching physician was involved. For more information on Medicare coverage and payment of virtual services in general, please see the CMS fact sheet here. CMS has advised that telehealth billing under the primary care exception with examination by the resident and supervision performed remotely, (billed in Place of Service 02), is under review for consideration. CMS is aware of the urgency and will process this review as timely as possible.
What is the recommended treatment for patients who are home, but tested positive for COVID-19?	The AAFP supports the CDC's guidance about care management for patients with COVID-19 here.
Does the AAFP recommend doing in-person physicals if no sick visits are done in the building?	The AAFP developed guidance on COVID-19 Preventive and Non-urgent Primary Care visits on rescheduling and postponing care. It provides support to members making recommended practice changes during the COVID-19 pandemic.
Is there any guidance on billing and charges for COVID-19 testing?	For commercial payers, billing requirements will vary by payer. Payer coding and billing policies can be found online.
Residents and medical students are being turned away from outpatient rotations in an effort to decrease risk of transmission, lack of personal protective equipment (PPE) and several other reasons. In addition to engaging residents in telemedicine visits, are there recommendations for how residents and medical students can stay engaged and offer care/support to our patients? There is a worry that residency programs and outpatient clinical experiences will be jeopardized over the coming months, especially in rural areas.	Patient and health care provider safety are of utmost importance during this COVID-19 crisis. We also recognize the importance of continued clinical learning and the valuable role that residents and medical students have in providing health care. It is difficult to keep learners involved in patient care without enough PPE. The AAFP is advocating strongly for an immediate adequate supply of PPE. We're hearing creative ideas from both residency and medical school student communities for clinical and learning opportunities. Examples from residencies include helping with triage, testing and stabilization in emergency departments, interacting with public health officials and other local, state and federal agencies, as well as stepping up with educational outreach to the communities they serve. In some programs, residents are calling highest-risk patients over the phone and teaching patients about COVID-19

	prevention, addressing refill needs, food, legal issues related to rent, and other needs. The calls may convert to telephone visits with a remote preceptor on standby. Other residency programs have created an emergency response rotation with several types of activities, including investigating and writing policies and processes for use in clinical settings to delineate how patient care will be delivered in this changing environment. These add to residents' experience in population health, health systems managements and quality improvement. Of course, family medicine residents have inpatient skills and non-COVID-19 skills (e.g., maternity care) and may find their skills are needed in those settings, too. Some medical schools are putting together curricula for students that include elements of these residency ideas, as well as virtual education opportunities. The AAFP Family Medicine Interest Group (FMIG) network is collecting ideas and efforts of students across the country for how they are staying involved. The FMIG network will publish what it has captured in a guest editorial in *AAFP News* soon. The AAFP is in the process of setting up a resident community to provide a discussion forum for residents to share ideas. Additionally, the AAFP will offer Board review materials without charge to residents. COVID-19 clinical and advocacy information is updated daily on our website. The AAFP COVID-19 community is a place where members of all types, including residents and students, can share their experiences. Other organizations are creating repositories of educational resources too. The Society of Teachers of Family Medicine (STFM) and Association of American of Medical Colleges (AAMC) have created resource hubs to capture ideas and resources, including virtual and distance learning. The Association of Family Medicine Residency Directors (AFMRD) has a COVID-19 Toolbox (login required) for program directors to share resources between residency programs. Residents and medical students provide valuable patient care. The AAFP is paying attention to and making sure we're hearing directly from residents

	and medical students to understand exactly how we can best support their needs.
What are the AAFP's recommendations for providing care for asymptomatic patients, well visits, stable rechecks, etc.?	The AAFP developed a policy on [COVID-19 Preventive and Non-urgent Primary Care]() visits on rescheduling and postponing care. It provides support to members making recommended practice changes during the COVID-19 pandemic.
Can the AAFP clarify the rules around billing for an in-person visit following a telehealth visit?	There are limits on when some telehealth services may be reported vis-a-vis an in-person visit. For instance, the descriptor for code G2012 includes language that makes clear it cannot originate from a related E/M service provided within the previous seven days nor lead to an E/M service or procedure within the next 24 hours or soonest available appointment. Similarly, CPT states that If within seven days of the initiation of an online digital E/M service (99421-99423), a separately reported E/M visit occurs, then the physician or other qualified health professional work devoted to the online digital E/M service is incorporated into the separately reported E/M visit. This includes E/M visits and procedures that are provided through synchronous telemedicine visits using interactive audio and video telecommunication equipment. If the patient initiates an online digital inquiry for the same or a related problem within seven days of a previous E/M service, then the online digital visit is not reported. However, if the patient generates the initial online digital inquiry for a new problem within seven days of a previous E/M visit that addressed a different problem, then the online digital E/M service may be reported separately.
Is it best practice for family physicians to encourage telephone-only visits for elderly patients to help minimize the fraud issues in the original telemedicine requirement?	The AAFP is advocating that CMS take the appropriate actions to classify codes 99441, 99442, and 99443 as covered services in the Medicare program and that CMS begin allowing physicians to bill for these services and that CMS issue payment for these services when billed by physicians.
Is the AAFP advocating for parity of reimbursement for telephone-only CPT and video visits?	The AAFP will advocate for appropriate payment for the telephone only CPT codes (99441-99443). Based on the current Medicare conversion factor and relative values assigned to those codes, Medicare's average allowance would range from $14.44 (5-10 minute call) to $41.14 (21-30 minute call).

Would it satisfy documentation if patients took blood pressure or blood glucose levels under video supervision, and showed physicians the results?	The AAFP does not know the answer to this. It may be dependent upon the payer.
Is the AAFP concerned about the pandemic causing negative, sustained changes to the relationship between insurance companies and telemedicine?	The AAFP is working to address this.
Is the AAFP aware of licensure changes to support broader use of telemedicine visits?	This is a rapidly changing situation. The Federation of State Medical Boards (FSMB) updates their information regarding waiving licensure requirements regularly. For inactive or retired physicians, here is a state-by-state summary. The FSMB's main COVID-19 page is here.
Can family physicians use telephone visits as a substitute for required date-driven Medicare visits in the nursing home?	CMS has not waived the requirement for a regulatory visit and has not stated that telephone visits can be used as a substitute. CMS has been asked to clarify this point as to whether required regulatory visits can be done via telehealth, and CMS has promised additional guidance.
Can Modifier 95 be used with the E/M code?	Modifier 95 (Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System) may be used with some E/M codes. Per CPT, "synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Modifier 95 may only be appended to the services listed in Appendix P of CPT." Those services include many E/M codes, such as 99201-99205 and 99212-99215.