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Embracing telemedicine into your otolaryngology practice amid the COVID-19 crisis: An invited commentary

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ABSTRACT

The COVID-19 pandemic has quickly and radically altered how Otolaryngologists provide patient care in the outpatient setting. Continuity of care with established patients as well as establishment of a professional relationship with new patients is challenging during this Public Health Emergency (PHE). Many geographic areas are under "stay at home" or "shelter in place" directives from state and local governments to avoid COVID-19 exposure risks. Medicare has recently allowed "broad flexibilities to furnish services using remote communications technology to avoid exposure risks to health care providers, patients, and the community." [1] The implementation of telemedicine, or virtual, services, will help the Otolaryngologists provide needed care to patients while mitigating the clinical and financial impact of the pandemic. The significant coding and billing issues related to implementing telemedicine services are discussed to promote acceptance of this technology by the practicing Otolaryngologist. Of particular importance, outpatient visit Current Procedural Terminology® codes (99201-99215) may be used for telehealth visits performed in real-time audio and video.

1. Introduction

The current Public Health Emergency (PHE) surrounding the COVID-19 pandemic, has required Otolaryngology practices to rapidly change from conventional face-to-face services to the provision of telemedicine, also known as virtual (non-face-to-face), services.

The Centers for Medicare & Medicaid Services (CMS), of the Department of Health and Human Services (DHHS) released guidance on March 30, 2020 further broadening access to Medicare telehealth services so that Medicare beneficiaries may receive a wider range of services from Otolaryngologists without having to travel to a healthcare facility [1]. CMS has issued an 1135 waiver which allows Medicare to pay for office, hospital, and other visits furnished via telemedicine across the country, including in patients' places of residence retroactive to March 1, 2020. Many telehealth visits performed by Otolaryngologists will be performed using real-time audio and video and will be billed using CPT codes 99201-99215. Non-Medicare payors are also issuing guidance on telemedicine, or virtual services. Otolaryngologists are encouraged to check non-Medicare payor policies as these are continually changing.

This Commentary focuses on Medicare guidance for telemedicine services since Medicare is a major payor in most Otolaryngology practices and many non-Medicare payors follow Medicare policies. We hope that Otolaryngologists will embrace this technology currently, as well as for the future, to foster and maintain essential patient care in the office setting.

1.1. Definitions: telehealth vs telemedicine

Many people use the terms "telehealth" and "telemedicine" interchangeably, but the definitions are not the same. Telehealth is a broad term that includes telemedicine as one type of service.

The Health Resources and Services Administration (HRSA), of the DHHS, defines telehealth as "the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration." [2]

The HRSA goes on to say:

> "Telehealth is different from telemedicine because it refers to a broader scope of remote healthcare services than telemedicine. While telemedicine refers specifically to remote clinical services, telehealth can refer to remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services."
>
> [3]

CMS refers to many remote clinical services at "telehealth visits" as opposed to calling them "telemedicine services". For purposes of this

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Commentary, we use the term "virtual services" to encompass four types of billable services:

1) telehealth services (Medicare's term) and telemedicine services,
2) telephone services (calls),
3) virtual check-ins, and
4) E-visits/digital online services.

2. Implementation considerations

2.1. New issues require new actions

The PHE surrounding the COVID-19 pandemic is the time to think out of the box and consider practicing in alternative and historically unconventional ways. Quick implementation of new processes and novel ways of providing Otolaryngic care is key to short-term practice sustainability. Many practices have implemented changes overnight, or very short-term, such as consolidating multiple practice sites to a single site and "drive by" allergy injections given in the practice's parking lot to prevent staff exposure to the COVID-19 virus.

Implementing virtual services in your Otolaryngology practice now is essential to maintaining current and future clinical and financial viability. Additionally, practices have had to do something practice management consultants have rarely recommended - holding claims for a period of time such as a week - to ensure compliance with payor billing guidelines.

Effective for services retroactive to March 1, 2020, and for the duration of the COVID-19 PHE, Medicare will make payment for virtual services furnished to patients in broader circumstances and with relaxed requirements [4]. Table 1 illustrates variations in key guidelines for Medicare's telehealth services guidelines prior to, and during, the PHE.

2.2. Modality/platform considerations

CMS continues to require an interactive real-time audio and video telecommunication system for Evaluation and Management (E/M) telehealth visits 99201-99215. A telephone call, without the real-time video component, does not meet the requirements for billing telehealth visit codes, 99201-99215, to Medicare. Refer to the section on telephone calls below for more information on audio without video services.

CMS has relaxed the rules requiring a HIPAA-secured platform and now allows non-HIPAA-secure applications for video chats, including Apple FaceTime, Zoom, Doxy.me, Facebook Messenger video chat, Google Hangouts video, Skype, etc. Applications that are "public facing" and not allowed include Facebook Live, Twitch, and TikTok.

Practices must notify patients that any third-party application potentially introduces privacy risks.

2.3. Medicare's payment rate

Prior to the PHE, Medicare paid performing providers at a reduced rate, the facility payment rate, for telehealth services reported using POS 02 (Telehealth). However, for all dates of service March 1, 2020 through the end of the current PHE, Medicare will pay the same amount for virtual services as it would if the service was provided in person. Medicare's non-facility rate will now be paid for claims submitted with POS 11 (Office) which is a higher rate than payment for claims billed with POS 22 (On Campus-Outpatient Hospital) or POS 19 (Off Campus-Outpatient Hospital).

Claims submitted with a POS in a hospital setting (e.g., 22, 19) will be paid at Medicare's facility rate. Claims submitted with a POS of 02 (Telehealth), because the service would have been performed via telehealth means, will also be paid at Medicare's facility rate.

For example, an established patient who would normally have been seen in the physician office is now seen using a real-time audio and video platform (e.g., Apple FaceTime, Doxy.me). An established patient visit CPT code, 9921x, is reported using POS 11 and the non-facility payment allowable will be paid. Modifier 95 must be appended to the E/M code reported which will be discussed later in this Commentary.

2.4. Who can bill, and be paid, for virtual services?

CMS allows payment for virtual services to the following providers typically seen in Otolaryngology practices:

- Physicians,
- Non-physician practitioners (NPP): nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists (CNSs), and
- Therapists such as speech-language pathologist (SLPs) and physical therapists (PTs).

CMS allows payment to audiologists only for diagnostic testing services; therefore, audiologists will not be paid by Medicare for telehealth services.

Table 1
Variations in key Medicare guidelines for telehealth services before and during the public health emergency.

Medicare before March 1, 2020 prior to PHE	Medicare after March 1, 2020 during PHE
Patient must be in a designated rural or underserved area	Patient may be anywhere in the country
Patient must go to an "originating site," such as a physician office or hospital, for most services	Patient may be in any site whether a healthcare facility or even their home
For some services (e.g., remote evaluation), patient must be an established patient	Patient may now be new or established
Provider must use a Health Insurance Portability and Accountability Act (HIPAA) compliant platform	Requirement for HIPAA compliant platform is waived
Requires two-way, real time audio/visual communication for a telehealth visit (99201-99215)	No change: requires two-way, real time audio/visual communication for a telehealth visit (99201-99215)
May only bill services on CMS list	No change: may only bill services on CMS list except for telephone calls (telephone calls are now payable by Medicare)
Payment to physician is at facility rate	Payment to physician is at the rate based on the billed place of service (e.g., POS 11 Office = non-facility payment rate, POS 22 On Campus-Outpatient Hospital = facility payment rate)
Evaluation and Management (E/M) code (99201-99215) must meet Current Procedural Terminology® (CPT)/CMS documentation requirements (e.g., new patient must meet or exceed all 3 of the 3 key components)	E/M code (99201-99215) is chosen based on Medical Decision Making (MDM) or total time
Bill place of service (POS) code 02 (Telehealth)	Bill POS code for where service would normally have been provided (e.g., POS 11 for physician office, POS 22 for hospital outpatient department, POS 02 for telehealth)
Do not use modifier 95 (Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System)	Use modifier 95

2.5. What services are covered?

A list of Current Procedural Terminology® (CPT) codes that may be used for synchronous (real-time two-way) telemedicine services is in Appendix P of the CPT codebook. The individual CPT codes are noted by the star symbol (⋆) in the CPT codebook.

CMS provides a list of covered CPT codes for what Medicare refers to as "telehealth visits" which include 9920x (new patient visit) and 9921x (established patient visit) codes and require use of a real-time audio and video modality. The entire list can be found at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. Recently, 80 new CPT codes were added to the list which include some therapy services.

Medicare also reimburses virtual check-in services as well as E-visits (digital E/M services) and now also pays for telephone calls (99441-99443, 98966-98968) during the PHE. CMS does not consider E-visits, virtual check-ins and telephone calls to be telehealth services.

2.6. Medicare's telehealth visits

Medicare has always included new patient (9920x) and established patient visit (9921x) codes on the approved list of telehealth services. Prior to the PHE, Medicare followed CPT guidelines for documentation of the key components (History, Examination, and Medical Decision Making). It was difficult for Otolaryngologists to code higher levels of new patient E/M codes (9920x) because all 3 of the 3 key components – History, and Examination and Medical Decision Making – were required.

Medicare now allows the E/M code for telehealth visits (assuming real-time audio and video), 99201-99215, to be chosen based solely on Medical Decision Making (existing guidelines – not the new 2021 guidelines) or total amount of time [1]. The History and Examination component documentation requirements have been waived during the PHE. However, don't forget that a clinically necessary History and Examination will still be needed to obtain prior authorization for diagnostic testing (e.g., CT, MRI, allergy) and/or surgery.

As a reminder, Medical Decision Making complexity is chosen based on 2 of the following 3 elements:

1) number of diagnoses or management options,
2) amount and/or complexity of data to be reviewed, and
3) risk of complications and/or morbidity or mortality.

This is good news for Otolaryngologists who would otherwise have chosen a lower level E/M code because the Examination component was not met. The approved Medicare telehealth visit codes (99201-99215) and their respective type of Medical Decision Making are illustrated in Table 2.

Alternatively, the telehealth visit code (99201-99215) may be chosen based on the total provider time. Total time is now defined as the total amount of time the billing provider incurs on the day of the visit. This includes time preparing for the service and does not have to meet face-to-face counseling guidelines. Support staff time should not be included. The typical amount of time for each telehealth visit E/M code (Tables 3, 4) must be met or exceeded to choose the CPT code.

Be sure to have good documentation of the MDM or time – whichever you use to choose the level of billed E/M code.

Table 2
CMS telehealth visit E/M code and required type of medical decision making.

CMS telehealth visit E/M code	Type of medical decision making
99211	Not applicable
99201	Straightforward
99202	
99212	
99203	Low complexity
99213	
99204	Moderate complexity
99214	
99205	High complexity
99215	

Table 3
CPT typical time compared to CMS total time for new patient visit E/M codes.

New patient visit		
CPT code	CPT time	CMS time for telehealth visit during PHE
99201	10 min	17 min
99202	20 min	22 min
99203	30 min	29 min
99204	45 min	45 min
99205	60 min	67 min

Table 4
CPT typical time compared to CMS total time for established patient visit E/M codes.

Established patient visit		
CPT code	CPT time	CMS time for telehealth visit during PHE
99212	10 min	16 min
99213	15 min	23 min
99214	25 min	40 min
99215	40 min	55 min

2.7. Modifiers

Table 5 illustrates the two most common modifiers used to report telehealth and/or telemedicine services.

Medicare stopped the use of modifier GT (Via interactive audio and video telecommunication systems) in 2017 when the place of service code 02 (Telehealth) was introduced. However, many private payors are still using modifier GT.

The remaining two scenarios where a different modifier is needed are not common in Otolaryngology. These are:

a) Billing under Critical Access Hospital Method II – use modifier GT (Via interactive audio and video telecommunication systems), or
b) The service is furnished for purposes of diagnosis and treatment of an acute stroke – use modifier G0 (G, zero) (Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke).

CMS is not requiring modifier CR (Catastrophe/disaster related) on telehealth service codes at this time. Check with private payors to determine their policies for using modifiers when reporting telehealth/telemedicine services.

2.8. Billed place of service (POS)

Medicare has relaxed the place of service rule that required a more formal originating site for telehealth visits during this PHE. The patient's home is now an approved place of service and all facilities are now approved originating sites. In other words, there are now no site of service or geographical limitations for the patient or the provider for telehealth visits (99201-99215). Do not use POS 12 (Home) on the claim for any virtual service.

If the provider is furnishing the telehealth service from their own home, list the provider's home address in Box 32 service location on the claim. The POS code is still where the service would normally have

Table 5
Two most common modifiers used for telehealth/telemedicine services.

CPT/HCPCS II modifier	Descriptor	Comments
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system	Medicare now temporarily requires modifier 95 on all claims for telehealth visits that would normally be performed as face-to-face visits such as an office visit (99201-99215).
GQ	Via asynchronous telecommunications system	Clinicians participating in the federal telemedicine demonstration programs in Alaska or Hawaii must submit the appropriate CPT or HCPCS code for the professional service along with the modifier GQ "via asynchronous telecommunications system."

Table 6
Key coding and billing parameters for telehealth visit examples.

Coding/billing parameter	New patient Telehealth visit example	Established patient Telehealth visit example
CPT code	99204	99213
Billed POS	11	11
Address	Provider office	Provider home
Modifier	95	95

been provided to the patient such as POS 11 for physician office or POS 22 for on-campus-outpatient hospital (e.g., HOPD-hospital outpatient department).

2.9. New patient example

Telehealth Visit Using HIPAA-Secure Platform [state name of platform such as Doxy.me or Zoom for healthcare].

History: This is an 89-year-old male seen at the request of Dr. Internist for a left parotid mass. The history is documented, and exam is within normal limits except complete paralysis of the left frontal branch and the branch of the left upper lip of the facial nerve as well as slight weakness of the left mandibular branch. A CT scan of the neck, ordered by the Internist, revealed an enlarged left parotid gland.

Diagnosis: Left parotid mass with facial nerve paralysis.

Plan: I reviewed the CT scan with the patient and counseled him about a possible left parotidectomy followed by radiation therapy in the postoperative setting. The indications, alternatives, benefits and risks were explained to the patient and his wife. They understand the need for surgery and we will schedule this as soon as possible considering the potential risk of exposure to COVID-19 at his advanced age. An in-office exam will be carried out once the COVID-19 crisis settles down or the mass increases in size.

Comments: The History and Examination documented do not "count" toward choosing the level of E/M code during the PHE. The Medical Decision Making (MDM) is Moderate Complexity because there is a new problem that does not need a work-up (Diagnosis and Management Options, 3 points) and a management option selected of elective major surgery (Risk, moderate), and the scans reviewed is limited Data (2 points). The MDM supports 99204.

2.10. Established patient example

A 79-year-old female is seen via Apple FaceTime while the patient was in her home and the Otolaryngologist was in her own home. This is a follow up for history of laryngopharyngeal reflux (LPR) with recurrence after a recent upper respiratory infection (URI). She had previously been treated with omeprazole and had done well and able to stop medication but had to restart recently due to the URI/cough. Her symptoms have persisted about a month and she has a foreign body sensation in her mid-throat. She restarted her omeprazole 20 mg twice a day which seems to be helping. Pertinent review of systems is negative. Exam shows a well-developed, well-nourished and well-groomed female appearing her stated age in no acute distress and without cough at this time. Diagnosis is probably recurrence of LPR. The patient will continue twice a day omeprazole for at least another 4 weeks. She will follow up if symptoms persist and we will proceed with direct laryngoscopy to further evaluate. She was advised to contact us immediately if her symptoms worsen. Additionally, she was advised to avoid alcohol, caffeine, not eat within 4 h prior to bedtime and call the office if not improved.

Comments: The History and Examination documented don't "count" toward choosing the level of E/M code during the PHE. The Medical Decision Making (MDM) is Low Complexity because there is an established problem (Diagnosis and Management Options, 2 points) that is worsening and a presenting problem of a chronic condition with exacerbation (Risk, moderate) with no Data reviewed or ordered. The MDM supports 99213.

Table 6 summarizes key billing and coding parameters for the above new patient and established patient examples.

2.11. Co-insurance and deductibles

The HHS Office of Inspector General (OIG) is allowing provider to reduce or waive cost sharing for telehealth services paid by federal healthcare programs [5]. Note that Medicare is not waiving the patient's financial obligation, rather, they are allowing the provider to waive the patient's portion. Some commercial payors are waiving the patient's portion and reimbursing the physician at the full allowable. Otolaryngology practices should monitor explanation of benefit (EOBs) forms, also called remittance advice, to ensure optimal payment and accurate adjustments.

2.12. Medicare's mandatory 2% sequestration reduction

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) temporarily suspended the mandatory 2% sequestration to the physician allowable during this PHE. The bad news is that that the CARES Act extends the sequestration policy through 2030 in exchange for this temporary suspension [6].

2.13. HCPCS II Code Q3014 (telehealth originating site facility fee)

The facility that hosts the patient and telecommunications means, remote/distant from the telemedicine provider, may report Q3014 to obtain payment for the expense incurred for the remote provider's evaluation. Originating facility site (also called "hosting facility") expenses include, but are not limited to, cost of the telecommunication, originating site staff, equipment, and the usual expense incurred to provide a service. Originating sites include a physician's office site remote to the telemedicine provider, hospital, rural health clinic, skilled nursing facility, and others identified by CMS. The originating site files a claim for Q3014 with place of service code (POS) 02 (Telehealth).

During this PHE, the patient will be at home for most telemedicine services provided by Otolaryngologists. The patient's home is not considered an approved originating site that qualifies for use of Q3014. HCPCS II code Q3014 should not be submitted to a payor by the distant Otolaryngologist.

Table 7
Physician and NPP telephone evaluation and management CPT codes.

CPT code	Descriptor	Comments
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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	-CMS now allows payment for telephone calls to new or established patients -Be sure to document the amount of time spent on the phone call -May be used by physicians or NPPs
99442	11–20 minutes of medical discussion	
99443	21–30 minutes of medical discussion	

2.14. Telephone calls (99441-99443, 98966-98968)

The telephone call CPT codes (99441-99443, 98966-98968) were previously non-covered and not payable by Medicare. However, telephone E/M services are now paid by Medicare for new and established patients due to the COVID-19 pandemic.

Additionally, while CPT states these codes are for established patients, Medicare now allows payment for telephone only E/M codes for new patients. The telephone E/M codes are shown in Table 7.

Physicians and NPPs, called "other qualified health care professionals" by CPT, (e.g., physician assistants, nurse practitioners, clinical nurse specialists) that bill using their own NPI should use 99441-99443. "Qualified non-physician health care professionals," such as speech-language pathologists and physical therapists, should use codes 98966-98968 for telephone assessment and management services, as shown in the table below. The codes in Table 8 are not payable for services provided by auxiliary personnel such as Registered Nurses (RNs), Licensed Vocational Nurses/Licensed Practical Nurses (LVNs/LPNs), Medical Assistants (MAs), Nursing Assistants (NAs), etc.

CMS also requires that therapists use the appropriate therapy modifier (GP for PTs, GN for SLPs) for their services. Remember, CMS allows payment to audiologists only for diagnostic testing and not for telephone calls and does not pay for telephone services provided by auxiliary personnel.

Modifier 95 is not appended to the telephone call codes, 99441-99443 or 98966-98968, since CMS does not consider these codes to be telehealth services.

2.15. Virtual check-ins (G2010, G2012)

Virtual Check-Ins (G2010, G2012) may now be performed for both new and established patients even though the code descriptor states "established patient." The purpose of these HCPCS II codes is to determine whether an E/M visit (9920x, 9921x) is needed. These services are initiated by the patient. Again, CMS allows payment to audiologists only for diagnostic testing and not for virtual check-ins and does not pay for these services if provided by auxiliary personnel.

The descriptor for G2010 is:

> "Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, 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."

The intent of G2010 is for the physician or other qualified practitioner, such as an NPP, to review photos or video information (e.g., recording of a cough) submitted by the patient to determine if a visit is required. The service may now be provided to a new or established patient when a related evaluation and management (E/M) service has not been provided in the previous seven days and does not lead to an E/M service within the next 24 hours or soonest available appointment. The provider responds to the patient by patient portal. If an office visit or other service (e.g., E/M service) is needed, and it is scheduled within 24 hours or the soonest available appointment, then G2010 would not be reported.

CMS now allows therapists to report G2010 and the appropriate therapy modifier (GP for PTs, GN for SLPs) must be appended.

The descriptor for HCPCS II code G2012 is:

> "Brief communication technology-based service, e.g., 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".

The intent of G2012 is that a physician or NPP would conduct a virtual check-in, lasting 5 to 10 minutes, using a telephone or other telecommunication device to determine whether an office visit or other service is needed. If an office visit or other service (e.g., E/M service) is needed, and it is scheduled within 24 hours or the soonest available appointment, then G2012 would not be reported.

CMS now allows therapists report G2012 and the appropriate therapy modifier (GP for PTs, GN for SLPs) must be appended.

A telephone service code (99441-99443) may be reported by physicians or NPPs, in place of G2012, if the time threshold is met and the service does not result in the need for an E/M service in the next 24 hours/next available appointment or the service is related to a previous E/M service in the past 7 days. CPT 99421 currently has a work relative value unit (wRVU) of 0.25 while the wRVU for G2012 is also 0.25 so there is no financial advantage for reporting one code over the other. However, the wRVUs for 99442 and 99443 are 0.50 and 0.75, respectively. Be sure to document the amount of time spent on the service to support the billed code.

Modifier 95 is not used with G2010 or G2012 because the codes are not considered a telehealth services by CMS.

Table 8
Non-physician telephone assessment and management service CPT codes.

CPT code	Descriptor	Comments
98966	Telephone assessment and management service provided by a qualified non physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion	-CMS now allows payment for telephone calls to new or established patients -Be sure to document the amount of time spent on the phone call -May be used by providers such as SLPs (use modifier GN) or PTs (use modifier GP) -Do not use for audiologists or auxiliary personnel
98967	11–20 minutes of medical discussion	
98968	21–30 minutes of medical discussion	

Table 9
Online digital E/M service codes for physicians/NPPs.

CPT code	Descriptor	Comments
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes	-CMS now allows payment to new or established patients
99422	11–20 minutes	-Be sure to document the amount of time
99423	21 or more minutes	-May be used by physicians or NPPs

2.16. E-visits/on-line digital evaluation and management services

There were new CPT codes in 2020 for online digital (e.g., EHR portal, email) E/M services, initiated by the patient, without an image or video included with the communication. The CPT codes are shown in Table 9.

A code in Table 9 may be reported by physicians or NPPs, in place of G2010, if an image or video was sent with the communication if the time threshold is met. CPT 99421 currently has a work relative value unit (wRVU) of 0.25 while the wRVU for G2010 is 0.18.

Medicare allows payment to SLPs and PTS for online (e.g., patient portal) assessment and management of patients. The HCPCS II codes used by healthcare professionals who don't bill directly to Medicare for E/M services, are noted in Table 10.

Modifier 95 is not used on an E-visit CPT or HCPCS II code because CMS does not consider these to be telehealth services. Finally, CMS allows payment to audiologists only for diagnostic testing and not for online services and does not pay for online services provided by auxiliary personnel.

In summary, Table 11 provides a high level and brief summary of information for certain virtual services provided to Medicare beneficiaries.

2.17. Other payors

Commercial payors and state Medicaid plans may set their own rules. Many are paying for virtual services because they follow Medicare's guidelines. Practices are encouraged to survey their top 5 payors on a regular, even daily, basis during this PHE to maintain compliance with payor guidelines.

3. Continuing telemedicine after the COVID-19 pandemic

Otolaryngologists may find that providing telemedicine/virtual services has been beneficial to their practice during this PHE. We recommend the following two actions if telemedicine/virtual services are continued after the COVID-19 pandemic:

1) Invest time and effort in exploring a long-term HIPAA-secure platform if one is now not being used, and
2) Develop written practice policies and procedures for providing telemedicine/virtual services.

4. Conclusion

As Otolaryngologists adapt to changing practice modalities during the COVID-19 Public Health Emergency, we encourage them to embrace telemedicine and all types of virtual visits. The Center for Medicare & Medicaid Services has relaxed guidelines during this time to facilitate non-face-to-face visits using non-HIPAA-secure platforms. Medicare's reimbursement for telehealth visits 99201-99215 (using real-time interactive audio and video means) will be at the same rate as the place of service the patient would normally have been seen (e.g., non-facility rate for place of service 11 physician office, facility rate for place of service 22 hospital outpatient). Otolaryngologists will likely find this method of patient care to be attractive and continue to incorporate virtual visits into their practices after the PHE has ended. A list of helpful resources is shown below.

Resources

1. KarenZupko & Associates, Inc. Telehealth Solutions Center, http://www.karenzupko.com/KZA-telehealth-solution-center-access, (accessed April 7, 2020)
2. KarenZupko & Associates, Inc. COVID-19 Practice Management Resources, http://www.karenzupko.com/covid-19-resources, (accessed April 7, 2020)
3. American Medical Association Quick Guide to Telemedicine in Practice, https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice, (accessed April 7, 2020)
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Kim Pollock, RN, MBA, CPC, CMDP is an Employee of KarenZupko & Associates, Inc.

Table 10
HCPCS II codes for non-physician professional online assessment and management.

HCPCS II code	Descriptor	Comments
G2061	Qualified non physician health care professional online assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes	-CMS now allows payment to new or established patients
G2062	11–20 minutes	-Be sure to document the amount of time
G2063	21 or more minutes	-May be used by SLPs (use modifier GN) or PTs (use modifier GP) -Do not use for audiologists or auxiliary personnel

Table 11
Brief summary certain virtual services provided to Medicare beneficiaries.

Type of service	Description of service	Modality	CPT or HCPCS II code	Place of service	Modifier	Comments
Medicare telehealth visit (other payors: telemedicine visit)	Evaluation and management	Audio and video/visual (e.g., Apple FaceTime)	CPT 99201-99215 See full list at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	-Where normally would have been provided (e.g., POS11-physician office, POS 22-HOPD, POS 02-Telehealth)	95	-Physicians and NPPs choose code based on Medical Decision Making or Time
Telephone call	Communication between the patient and provider via the telephone only	Phone (audio only)	CPT 99441-99443: Physician/NPP CPT 98966-98968: SLP/PT	-Where normally would have been provided (e.g., POS11-physician office, POS 22-HOPD). -These are not telehealth services (meaning no POS 02)	Do not use modifier 95	-SLPs use therapy modifier GN -PTs use therapy modifier GP -Codes may not be reported by audiologists or auxiliary personnel
Virtual check-in	Brief (5–10 min) check in with the patient to determine whether an office visit is needed.	Includes phone (audio), digital (e.g., patient portal, secure text) depending on code	HCPCS II G2010 HCPCS II G2012			
E-visit	Communication between patient and provider through an online patient portal	Digital (e.g., patient portal)	CPT 99421-99423: Physician/NPP HCPCS II G2061-G2063: SLP/PT			

References

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