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ORIGINAL ARTICLE

An Invitation to Commentary on Using Telemedicine within Otolaryngology Practice during the Covid-19 Catastrophe

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ABSTRACT

The COVID-19 epidemic had a significant impact on how otolaryngologists deliver care and treatment to their patients in the outpatient setting. Throughout this Public Health Emergency (PHE), maintaining a continuum of care with existing patients and establishing a relationship with potential patients is difficult. State and municipal governments have issued orders for the citizens to remain at homes and stay under shelters in several places to prevent the spread of COVID-19.Wide adaptability in providing services via remote communications technology has been allowed to avoid exposure concerns to healthcare professionals, patients, and the general public. The use of telehealth or online services will allow otolaryngologists to provide essential care to patients while reducing the pandemic's clinical and budgetary burden. It increases the continuum of care, lowers costs, and enhances patient self-management and overall results, according to studies, notably in the treatment of distinct disease states. [1]The considerable coding and billing challenges associated with deploying telehealth services are explained to encourage otolaryngologists to adopt this technology.

INTRODUCTION

Due to the ongoing Public Health Emergency (PHE) involving the COVID-19 outbreak, otolaryngology practices have been forced to quickly transition from traditional face-to-face treatments to telehealth, also known as online (non-face-to-face) treatments. The World Health Organization defines telemedicine as "the detection, management, and preventing disease and injuries, research and assessment, and teaching of health care workers delivered at a distance utilizing electronic means." [2] In medical settings, medical professionals may now swiftly obtain data that can aid in the identification of ailments and the creation of efficient treatment methods with the help of the Internet. [3] On April 29, 2020, CMS of the DHHS issued guidelines to expand medical telehealth services, allowing medicare beneficiaries to begin a broader array of amenities from otolaryngologists with no need of commuting to a medical facility. CMS has authorized an 1135 waiver, allowing medicare to fund telemedicine offices, hospitals, as well as other appointments throughout the country, such as in patients' homes, retroactive to April 1, 2020. The interim exemption from certain telehealth compensation standards permits more widespread usage of telehealth services that involve real-time interactive sound and visual telecommunications links between the patient and the doctor. [4] Several telemedicine appointments by otolaryngologists will use actual video and audio, and CPT codes 99201-99215 will be used to bill them. Non-medicare payers are also releasing telehealth or online solutions recommendations. Non-Medicare payer regulations are always evolving, therefore otolaryngologists should monitor them. Because medicare is a key payer throughout many otolaryngology offices and many non-medicare payers follow medicare policies, the said commentary concentrates on medicare recommendations for telehealth services. We wish that otolaryngologists will adopt this innovation now and in the coming future to nurture and preserve critical care delivery in the office.

Definition: telehealth and telemedicine: Most individuals confuse the phrases "telehealth" & "telemedicine," yet the two concepts have different definitions. Telehealth is a broad phrase that encompasses a variety of services, including telemedicine. Even though the terms are used interchangeably, telehealth focuses on health services encompassing all health care professions (which would include health-care professional education), whilst telemedicine solely pertains to services provided by clinicians. [5] Moreover, the HRSA states: "Telehealth is distinct about telemedicine in that it encompasses a greater range of distant medical services. In addition to the healthcare services, telehealth also relates to distant non-clinical facilities including provider training, administrative meetings, and continuous medical training "[6] Most virtual medical services are referred to as "telehealth visits" by CMS rather than "telemedicine services."

Application Considerations

New concerns require new arrangements: The current PHE surrounding the coronavirus epidemic is an excellent opportunity to ponder outside the box and contemplate working in novel and previously unusual ways. The emergence of modern innovation is changing healthcare administration, with telehealth becoming a significant contributor to this transition[7]. To limit staff interaction with the COVID-19 virus, several practices have undertaken measures overnight or temporarily, such as combining numerous practice sites into a singular location and administering "drive-by" allergy shots in the parking lot. [8]

Online services are critical to preserving your otolaryngology practice's ongoing and prospective medical and economic sustainability. Furthermore, to assure

compliance with payment billing requirements, practices had to resort to something that practice administration consultants seldom suggest: hold claims for a length of time, such as a week. Medicare will compensate for online services delivered to patients in a larger range of scenarios and with fewer limitations beginning from April 1, 2020, and for the length of the coronavirus PHE. Table 1 shows how important medicare telehealth activities rules varied before and throughout the PHE.

Table 1: Variations in major Medicare regulations for telehealth activities before and throughout the PHE.

Medicare before PHE i.e. April 1, 2020	Medicare throughout PHE, after April 1, 2020
The patient should be residing in a rural or underserved location.	The patient could be located in any placein the country
For many facilities, the patient should go to an "originating site," for example a doctor's office or a clinic.	The patient could be in any location, including a hospital or their own residence.
The patient should be a registered patient for various services (e.g., remote assessment).	The patient could be new or old at this point.
The provider must employ a platform that complies with the Health Insurance Portability and Accountability Act (HIPAA).	The need for a HIPAA-compliant platform is no longer required.
For a telehealth consultation, two-way, real-time audio/visual interaction is required.	No changes: telehealth visits demand two-way, real-time audio/visual interaction
Only those services included in the CMS list may be billed.	No changes: you can only charge for services on the CMS list, except phone calls (which are currently covered by Medicare).
Physicians are paid at the institutional rate.	Payment to physicians is based on the billed service location.
Current Procedural Terminology® (CPT)/CMS paperwork criteria must be met for the Evaluation and Management (E/M)	Medical Decision Making (MDM) or total time are used to determine the E/M code (99201-99215).

Modality/platform considerations: The standards for invoicing telehealth visit codes, 99201-99215, to medicare are not met by a phone conversation with the absence of the real-time video element. CMS has eased the restrictions mandating a HIPAA-secured system, allowing non-HIPAA-secure programs such as Face Time, Zoom, Google meet, and others to be used for video conversations. Facebook Live and TikTok are examples of "public-facing" apps that are not permitted. Patients must be informed that any third-party application may pose a risk to their privacy.

Medicare's payment rate: Throughout all dates of service from April 1, 2020, to the end of the prevailing PHE, Medicare will cover the equal amount for online services as it would for in-person treatments. Claims filed with POS 11 (Office) will then be covered at the non-facility price that is greater than claims invoiced with POS 02or POS 09. Claims filed in a clinical environment with a POS (e.g., 22, 19) will be covered at the institutional rate determined by Medicare. Since the treatment would be provided via telehealth, claims having a POS of 02 (Telehealth) will also be funded at Medicare's facility rate. The E/M code should be attached with modifier 90, which will be addressed later in this Commentary.

Who has the authority to bill and be paid for online services?: CMS authorizes online services to be paid to the following providers who are commonly encountered in otolaryngology practices**:**

- Physicians,
- Non-physician practitioners (NPP): nurse practitioners (NPs), physician assistants (PAs), clinical nurse specialists (CNSs), and
- Therapists which include speech-language pathologists (SLPs) and physicaltherapists (PTs).

CMS solely pays audiologists for diagnostic testing facilities; consequently, Medicare would not reimburse audiologists for providing telehealth facilities.

What services are included in the package?: In Attachment P of the CPT codebook, you'll find a set of CPT codes that can be utilized for simultaneous solutions. The symbol (*) in the CPT codebook denotes specific CPT codes. 90innovative CPT codes were reportedly included in the list, including several therapy treatments. CMS replied on April 30, 2020, by permitting compensation for regular psychotherapy telephonic contact with patients using CPT codes. [9] Online check-in consultations, E-consultations (digital E/M services), and now phone conversations are all covered by Medicare throughout the PHE. E-visits, online check-ins, and phone conversations are not considered telehealth facilities by CMS. [10]

Medicare's telehealth consultations: The authorized list of telehealth facilities has historically contained fresh patient and recognized patient consultation codes. Previously, Medicare documented the major elements (history, evaluation, and clinical decision-making) using CPT standards. All three main elements – history, evaluation, and clinical decision making – were necessary. The E/M code for telehealth consultations (assuming real-time sound and visuals), can now be selected simply based on medical decision making or the overall length of time spent. [11] Throughout the PHE, the paperwork criteria for the history and evaluation components were abolished. However, keep in mind that obtaining prior approval for identifying tests (e.g., CT, MRI, allergies) operation will nonetheless require a clinically required History and Evaluation. As a refresher, the level of medical decision making complexity is determined by two of the three factors listed below:

1 The number of diagnoses or treatment choices to be considered,

2 The number or intricacy of information to be examined, and

3 The threat of difficulties, morbidity, or fatality.

Table 2 shows the accepted Medicare telehealth appointment codes and their associated medical decision-making category.

Instead, the entire clinician time can be used to determine the telehealth appointment code. Overall time is presently described as the overall length of time spent on the day of the consultation by the billing supplier. This does not have to fulfill face-to-face counseling criteria and

comprises of time spent prepping for the session. Time spent by supporting employees should not be counted. To determine the CPT code, the normal length of time for every telehealth consultation should be met or surpassed.

Table 2: CMS telehealth consultation E/M code and necessary type of clinical decision making

CMS telehealth consultation E/M code	Category of clinical decision making
99010	Unacceptable
99020 99030 99036	Straightforward
99040 99050	Less complication
99070 99077	Moderate level of complication
99080 99090	High level of complication

Table 3: CPT usual duration matched with CMS overall time for fresh patient consultation E/M codes

Fresh patient visit		
CPT codes	CPT time	CMS time for telehealth visit throughout PHE
99010	Ten minutes	Seventeen minutes
99020	Twenty minutes	Twenty-two minutes
99030	Thirty minutes	Twenty-nine minutes
99040	Forty-five minutes	Forty-five minutes
99050	Sixty minutes	Sixty-seven minutes

Table 4: CPT usual duration matched with CMS overall time for registered patient consultation E/M codes

Registered patient consultation		
CPT codes	CPT time	CMS time for telehealth consultation throughout PHE
99012	Ten minutes	Sixteen minutes
99022	Twenty minutes	Twenty-three minutes
99036	Thirty minutes	Forty minutes
99047	Forty-five minutes	Fifty-five minutes

Modifiers: The two major prevalent modifiers used to represent telehealth and/or telemedicine treatments are shown in Table 5. When the location of treatment code 02 (Telehealth) was created in 2017, Medicare ceased using modifier GT (Via interactive sound and visual communications devices). Several private funders, however, continue to use modifier GT. In otolaryngology, the other two circumstances in which a separate modifier is required are uncommon. These are the following:

A Utilize modifier GT (Via interactive sound - visual telecommunication methods) or b) If the treatment is provided for the diagnosis and therapy of an intense stroke, utilize modifier G0 (G, zero) (Telehealth services provided for the diagnosis, assessment, or management of signs of an intense stroke).

When documenting telehealth services, consult with a private provider to see what their regulations are on applying modifiers.

Table 5: Two commonly used modifiers for telehealth/telemedicine services

CPT/HCPCS II modifier	Descriptor	Comments
90	A real-time interactive sound-visual telecommunications network is used to provide concurrent telemedicine services.	Modifier 90 is now required on every claim for consultations that would typically be conducted as in real-lifeconsultations, including a visit, by Medicare for the time being.
HW	Via concurrent telecommunications network	Doctors in Alaska and Hawaii who participate in government telemedicine demonstrations programs must provide the relevant CPT or HCPCS code for the medical service, as well as the modifier GQ "through a synchronous communications network."

Billed place of service (BOS): Throughout this PHE, Medicare has eased the location of service requirement, which formerly mandated a more official originating point for telehealth encounters. [12] All institutions are currently authorized origination locations, and the client's residence is as of right now an authorized location of service. In other terms, telehealth encounters no longer have a location of the facility or geographical restrictions for the client or the physician. On any online service claim, do not use POS 12 (Home). List the supplier's residential address in Box 32 delivery site on the claim if the telehealth support is delivered from the provider's residence.

Example of a fresh patient: Background: This is an 89-year-old man who was seen for a left parotid tumor. Except for full immobility of the left hemisphere branch and the stem of the left top lip of the facial nerve, and also minor impairment of the left mandibular branch, the background was recorded, and the assessment was within acceptable bounds. The internist requested a CT scan of the neck, which detected an enlarged left parotid gland.A left parotid tumor with facial nerve impairment was the diagnosis.

Plan: I studied the CT scan with the client and advised him on the possibility of a left parotidectomy with radiation treatment as a follow-up procedure. The client and his spouse were informed about the reasons, options, perks, and hazards. They realize the importance of the operation, and it will be scheduled as soon as feasible, given the risk of COVID-19 infection at his older age. Once the COVID-19 crisis has passed or the mass has grown larger, an in-office examination will be performed.

Remarks: Throughout the PHE, the recorded background and evaluation do not "count" towards determining the level of E/M code. Since a new issue exists which does not require a work-up (diagnosis and treatment Options, 3 points) and a treatment choice of elective major operation (threat, medium), and the scans evaluated are restricted, the medical decision making was of moderate difficulty (2 points).

Example of registered patient: A woman who was of 79 years was viewed via iPhone facetime when the client and the otolaryngologist were both at their residences. The said appointment was a follow-up appointment for recurrent laryngopharyngeal reflux (LPR) following a previous upper respiratory infection (URI). She had formerly been medicated with omeprazole and had progressed well

enough to be able to quit it, but owing to the URI/cough, she had to resume it suddenly. Her symptoms had been bothering her for nearly a month, and she was experiencing a strange feeling in her mid-throat. She began taking 20 mg of omeprazole two times a day again, and it appeared to be working. A thorough examination of systems wasunfavorable. At this moment, the exam reveals a strong, well-nourished, and well-presented woman of who was in no severe discomfort and has no complaint. LPR relapse was most likely the diagnosis.She took omeprazole two times a day for at minimum another four weeks. If her condition persists, we will perform a thorough laryngoscopy to better assess her condition. She was told to call us right away if her condition worsened. She was also instructed to restrict drinking caffeine, not consume before 4 hours of sleeping, and contact the office if her condition did not progress. Comments: Throughout the PHE, the recorded history and evaluation do not "count" towards determining the level of E/M code. Since there was a documented issue (Diagnosis and Treatment Options, 2 points) that is deteriorating and a visible issue of a persistent condition with aggravation (Threat, medium), the Medicinal Decision Making is Low Complex.For the preceding fresh patient and existing patient instances, Table 6 outlines essential invoicing and coding criteria.

Table 6: Key coding and invoicing limitations for telehealth consultation examples.

Coding/invoicing parameter	Fresh patient Telehealth consultation example	Registered patient Telehealth consultation example
CPT code 99044 99010	CPT code 99044 99010	CPT code 99044 99010
Invoiced POS	12 12	12 12
Address	Provider office	Provider residence

Co-insurance and deductibles: The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) is authorizing providers to cut or eliminate cost contributions for telemedicine facilities covered by government healthcare programs. [13] It was observed that Medicare is enabling the physician to forego the client's share of the financial responsibility. Some private funders are eliminating the patient's part of the bill and refunding the provider in full. To guarantee maximum reimbursement and appropriate modifications, otolaryngology practices should examine an explanation of benefit (EOB) documents, often known as remittance advice.

Medicare's compulsory 2% sequestration decrease: Throughout this PHE, the Coronavirus Aid, Rehabilitation, and Economic Security Act (CARES Act) briefly halted the mandated 2% reimbursement to the doctor. The unfortunate thing is that the CARES Act, in return for this interim moratorium, continues the budget program until 2030. [14, 15]

HCPCS II Code Q3055: The institution hosting the client and telecommunication methods, which is peripheral from the telemedicine physician, may file Q3055 to receive reimbursement for the cost of the virtual provider's assessment. Costs associated with an initiating facility site (also known as a "hosting facility") comprise, but are not restricted to, communication costs, originating site workers, technology, and the regular costs associated with providing a service. A distant doctor's workplace site, a hospital, a regional health clinic, a specialized nursing institution, and others specified by CMS are examples of originating sites. The originating site submits a request for Q3055 with the code for the location of the facility.The person will be at residence for many telemedicine cares rendered by otolaryngologists throughout this PHE. Q3055 cannot be used at the client's residence because it is not an authorized originating site. The remote Otolaryngologist should not transmit HCPCS II code Q3055 to a bill payer.

Telephone calls: Formerly, Medicare did not reimburse or pay for phone call CPT codes. Owing to the COVID-19 epidemic, Medicare currently covers telephone E/M facilities for potential and existing patients.

Furthermore, while CPT indicates that the codes exist for current patients, Medicare nowadays allows potential patients to be paid for phone-only codes. Table 7 lists the E/M codes for telephones. Doctors and NPPs (e.g., medical assistants, registered nurses, nurse practitioners) who bill using their own NPI should utilize 99051-99064.

For telephonic evaluation and management treatments, "trained non-physician care providers," such as speech-language therapists and physiotherapists, should use codes 98066- 98908.

CMS also mandates clinicians to apply the proper therapy modifier for respective services (GP for PTs, GN for SLPs). Note that CMS solely pays audiologists for diagnostic tests, not for phone conversations, and it does not compensate for supplementary personnel's telecommunications services. Because CMS does not recognize the phone conversation codes 99041- 99043 or 98906-98908 to constitute telehealth services, modifier 90 is not added to them.

Table 7: CPT codes for doctor and NPP phone assessment and management.

CPT code	Descriptor	Comments
994401	A doctor or other skilled medical professional may deliver a telephone assessment and management facility to an existing patient or custodian that does not stem from a linked E/M service offered within the preceding 7 days or that leads to a service or process over the next 24 hours or earliest possible accessible consultation; Medical conversation for 7–12 minutes	Funding for phone conversations with new or existing patients is now permitted by CMS.
994402	12-22 mins	Can be used by doctors or NPP's.
994403	22-32 mins	

Table 8: Non-physician phone evaluation and management service CPT codes

98966	A skilled non-physician clinical professional provides a cell phone assessment and managing facility to an existing patient, parent, or custodian that is not linked to a preceding evaluation and management facility and does not give rise to an evaluation and supervision offering or process over the next 24 hours or earliest possible available consultation; 7–12 mins	-CMS now authorizes fees for calls to fresh or existing patients -Make sure to record the time of conversation
98067	12–22 mins	PTs (use modifier GP) -Don't utilize for audiologists
98068	22–32 mins	or support staff

Table 9: Virtual E/M facility codes for doctors/NPPs

CPT code	Descriptor	Comments
99021	For an existing patient, an interactive web assessment and management service are available for 7 days, a total time of 7–12 mins.	-CMS permits payment to fresh or existing patients -Ensure that the time of the call is being recorded
99022	12–22 mins	Can be used by doctors or NPPs
99023	22+ mins	

Table 10: HCPCS II codes for digital evaluation and monitoring by non-physician professionals.

HCPCS II code	Descriptor	Comments
G2071	For an existing patient, certified non-physician medical care expert digital evaluation and monitoring service for 7 days, overall time throughout the 7 days; 7–12minutes	CMS permits payment to fresh or existing patients -Ensure that the time of the call is being recorded
G2072	12–22 minutes	Can be utilized by SLPs or PTs
G2073	22 or more minutes	Can't be utilized for audiologists or support staff

Table 11: In a summary, Medicare recipients can use the following online services.

Type of Facility	Description of service	Modality	CPT or HCPCS II code	Place of service	Modifier	Comments
Medicare telehealth consultation (other payers: telemedicine consultation)	Assessment and monitoring	Sound and visual (example Google meet or facetime)	CPT 99001-99015	-Where usually would have been offered (e.g., POS12-physician office, POS 20-HOPD, POS 01-Telehealth)	90	Doctors and NPPs can make a choice of code based on clinical Decision Making or Time
Phone call	Conversation between the doctor and the patient through phone call	Only audio	CPT 99041-99043: Doctor/NPP CPT 98066-98068: SLP/PT	Where usually would have been offered (e.g., POS12-physician office, POS 20-HOPD).	Do not use modifier 90	SLPs use therapy modifier GQ
Virtual check-in	(7–12 mins) Consult with the client to see if an appointment with the doctor is necessary.	Comprises of phone (audio), online (e.g., patient portal, secure text) depending on code	HCPCS II G2000 HCPCS II G2002			
				These are not telehealth facilities (meaning no POS 01)		Codes may not be reported by audiologists or auxiliary
						personnel
E-visit	Conversation between patient and doctor through a digital patient portal	Digital	CPT 99021-99023: Doctor/NPP HCPCS II G2071-G2073: SLP/PT			

Virtual check-ins: The patient is the one who initiates these services. Again, CMS only pays audiologists for investigative testing, not for online check-ins, and therefore does not recompense for virtual check-ins. If these services

are performed by auxiliary staff, you must pay for them. G2010 has the following descriptor: Remote evaluation of records were submitted by patients within 24 business hours, not originating from previous 7 days.

The goal of G2010 is for a physician or other competent practitioner, such as an NPP, to analyze pictures or video material (e.g., a cough recording) given by the patient to assess whether or not a visit is necessary. The patient portal is used by the provider to respond to the patient. If a medical appointment or other facilities (e.g., E/M service) is desired and can be scheduled within 24hrs or the next scheduled appointment, G2010 is not recorded. Services were provided by physician who can report services according to HCPCS 11 code G2011.

Clinicians can now record G2011 with the appropriate therapy modifier attached. Doctors or NPPs may document a phone service code (99441-99443) rather than G2011 if the time target is crossed and the facility does not give rise to the requirement for an E/M service in the next 24 hours accessible consultation or the facility is linked to a past E/M service in the past 7 days.The wRVUs for 99042 and 99043, on the other hand, are 0.50 and 0.75, respectively. To support the billing code, make sure to keep track of how much time you spend on the service. G2010 and G2011 are not deemed telehealth services by CMS, modifier 90 is not applied.

E-visits/digital assessment and monitoring services over the internet: The new CPT codes issued are listed below in table No. 9. In place of a code from Table 9, physicians or NPPs may record a code from Table 9. G2010, if the communication included a picture or video if thetime limit has been reached. CPT 99421 has a work relative value at the moment. Table 10 shows the HCPCS II codes that medical providers who do not charge Medicare straightforwardly for E/M facilities utilize. Modifier 90 is not implemented since CMS does not regard E-visit CPT or HCPCS II codes to constitute telehealth activities. Ultimately, CMS solely reimburses audiologists for diagnostics, not for electronic services, and supplementary staff is not reimbursed for virtual services. To a greater extent and in a simplified way, Table 11 summarizes information about various online services provided to Medicare participants.

Other funders: Private funders and state Medicaid plans have the authority to describe their standards. As they follow Medicare's requirements, many people are paying for virtual treatments. Throughout this PHE, practices are invigorated to review their top 5 funders on a consistent, even daily, basis to ensure that they are following funding rules.

Prevalence of telemedicine pandemic: Throughout this PHE, otolaryngologists may discover that giving telemedicine/online amenities has been advantageous to their practice. If telemedicine/online facilities are extended after the pandemic, we advocate the following two actions:

1 Spend time and energy looking into a longstanding HIPAA-secure network if one isn't already in place.

2 Create written practice standards and measures for giving telemedicine/virtual amenities.

CONCLUSION

According to studies, the efficiency of telehealth services and the clinical result of cases throughout telehealth consultations can be comparable to traditional face-to-face consultations, with the added benefit of better access to medical treatment. Throughout their training, otolaryngologists must adapt to new practice methods.We encourage them to embrace telemedicine and all sorts of virtual visits during the COVID-19 Public Health Emergency. During this time, the Centers for Medicare & Medicaid Services (CMS) has eased its requirements. Non-HIPAA-secure platforms are used to aid non-face-to-face appointments.

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