Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Telehealth: Helping your patients and practice survive and thrive during the COVID-19 crisis with rapid quality implementation

To the Editor: Telehealth is an effective, efficient way to triage and deliver timely, quality medical care. In the setting of this public health emergency, telemedicine can maintain access and continuity of care for patients, support colleagues on the front line, optimize in-person services, and minimize infectious transmission of COVID-19 coronavirus.

On March 17, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a 1135 Waiver and expanded telehealth coverage for all Medicare patients during the COVID-19 pandemic.

What does this mean for clinical practitioners? In short, telemedicine can be used for the evaluation and management of most patients. CMS's policy changes effectively eliminate the main barriers to telemedicine implementation: lack of reimbursement, licensing restrictions, and Health Insurance Portability and Accountability Act (HIPAA) compliance (Table I). Given current Centers for Disease Control and Prevention guidelines, in-person care should be limited to only the most urgent patients. This minimizes risk of COVID-19 transmission and ensures that finite clinical resources will be equitably distributed to those that need it most.

In the CMS guidance,[3] many restrictions that have roadblocked telehealth adoption for decades have been removed to promote "good faith use of telehealth" in these unprecedented times. To preserve both patient and society's trust, medical communities must hold our standards for professionalism and quality care high. Adherence to state regulations,[2] thorough clinical intake, clear and consistent video connectivity and images, documentation, patient education and transparency, care coordination, data security, and patient privacy should remain a top priority, even in times of crisis. If a non-HIPAA compliant platform is used initially, conversion to a HIPAA-compliant platform should be encouraged as soon as possible.

Telehealth offers a tool to provide accessible quality care and maintain connectivity while practicing social distancing. Thoughtful implementation[1,4,5] of telehealth now allows for sustainable and scalable practice beyond the current crisis.

We recommend the following steps for implementing telemedicine into outpatient practices:

1. Use existing systems and platforms (patient portals) to encourage patients to initiate telemedicine when available.
2. Identify highest-risk or urgent patients and schedule them for telemedicine visits.
3. Defer all nonessential visits until a later time.
4. Develop an established pathway for contact and evaluation for urgent patients.
5. Make sure patients know there is a clear line of communication to minimize emergency department overuse for noncritical issues.

In the last weeks, we have been proud of the quick actions of our colleagues to adapt and change their way of practice. However, there will always be questions as clinicians change the way they practice. Will telemedicine provide the same quality care as in person? How can we foster patient relationships with electronic distance? Unfortunately, we do not have the resources to see most patients in person, nor can we risk exposing otherwise healthy people to COVID-19. With telehealth implementation, we can see patients remotely, whereas we would not have seen them at all.

We anticipate that these changes are necessarily difficult, and our system will grow in new ways. Together as physicians, we will inevitably learn new things about allocating resources, improving efficiency, and optimizing our health system by using telehealth to tackle this pandemic.

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Table I. Updates in telehealth policy in the COVID-19 crisis*,+

	Pre-COVID-19 telehealth policy*	COVID-19†
Physician licensure	Providers must be licensed in state of the patient	Waived but state regulations apply.
Patient population	Established patient of the practice (within 3 years)	New or established patients
Patient location	Eligible originating sites Rural communities (HRSA)	All settings, including patient's home.
Technology[1]	Synchronous (live-interactive) Asynchronous (store & forward)	No change.
Privacy and security	HIPAA compliance	Not enforced.
Synchronous E-visit (provider to patient)	Codes: 99201-99215 Only for established patients in eligible originating sites and geographic locations. Place of Service code: POS 02 Co-insurance/deductibles apply	May be reimbursed at the same amount as in-person visits, when using an interactive audio and video telecommunications system permitting real-time communication between distant site and patient at home.^ Providers have flexibility in reducing/waiving out-of-pocket costs for patients. New or established patients Place of Service code: POS 11>>> Modifier: 95<< E/M level selection can be based on MDM or time**
Asynchronous E-visit using patient portal (provider to patient)	Codes: 99421-3 Place of Service code: POS 02 Established patients only.	New or established patients Place of Service code: POS 11>>> Modifier: 95<<<
Interprofessional E-consultations (provider to provider)	Synchronous, asynchronous, or telephone New or established patients Codes: 99446-99452 Place of Service code: POS 11	Place of Service code: POS 11>>> Modifier: 95<<<
Virtual check-in (provider to patient)	Synchronous, asynchronous, or telephone - Patient initiated - Established patients only - Brief, 5-10 minutes - Cannot result from/lead to E/M service within previous 7 days or next 24 hours. - Low reimbursement Codes: G2010 (asynchronous) G2012 (synchronous) Place of Service code: POS 02	New or established patients Place of Service code: POS 11>>> Modifier: 95<<<
Other payers		
Medicaid	By state[2]	Evolving by state
Private	By state[2] Billing modifier 95 (synchronous)	Evolving[1]

E/M, Evaluation and management; *HIPAA*, Health Insurance Portability and Accountability Act; *HRSA*, Health Resources and Services Administration.
*Medicare policy unless otherwise stated.
+Please see AAD Teledermatology Toolkit for the most up to date codes and resources.[1] †CMS is expanding telehealth on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. The Department of Health and Human Services (HHS) is announcing a policy of *enforcement discretion* for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8). Changes also include the Interim Rule issued March 30, 2020. ^Retroactive coverage to March 6, 2020. >>>Practitioners who bill Medicare telehealth services should report POS code that would have been reported had the service been furnished in person. <<<Before COVID-19, Medicare used POS 02 to identify telehealth services; however, due to the change in POS code to increase reimbursement, Medicare requests the use of modifier 95 to describe services furnished by telehealth.
**Time defined as all of the time associated with E/M on the day of service.

REFERENCES

1. American Academy of Dermatology Teledermatology Toolkit. Can dermatologists use telemedicine to mitigate COVID-19 outbreaks? Available at: practice/telederm/toolkit. Accessed March 20, 2020.
2. Center for Connected Health Policy. Federal and State Regulation updates. Available at: https://www.cchpca.org. Accessed March 20, 2020.
3. Centers for Medicare & Medicaid Services. Medicare Telemedicine Healthcare Provider Fact Sheet: Medicare coverage and payment of virtual services. Available at: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet?inf_contact_key=38ca3f198618fc3aeba4091611f5b055680f8914173f9191b1c0223e68310bb1. Accessed March 20, 2020.
4. American Telemedicine Association. COVID-19 (coronavirus). Available at: https://info.americantelemed.org/covid-19-news-resources. Accessed March 20, 2020.
5. American Medical Association. AMA quick guide to telemedicine in practice. Available at: https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice. Accessed March 20, 2020.

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