Teledermatology Fast Facts

George Han, MD, PhD

Due to the impact of the coronavirus disease 2019 (COVID-19) pandemic, many patients are working from home, which has led to a unique opportunity for dermatologists to step in and continue to care for their patients at home via telemedicine. With recent waivers and guidance from the Centers for Medicare & Medicaid Services (CMS), insurance coverage has been expanded for telehealth services, usually at the same level as an in-person visit. This editorial provides guidance for implementing telehealth services in your practice, and a tip sheet is available online for you to save and print. Please note that this information is changing on a day-to-day basis, so refer to the resources in the Table to get the latest updates.

Important Telehealth Resources for Dermatologists

Alliance for Connected Care: http://connectwithcare.org /state-telehealth-and-licensure-expansion-covid-19-chart/
American Academy of Dermatology Teledermatology Toolkit: https://www.aad.org/member/practice/telederm/toolkit
Center for Connected Health Policy: https://www.cchpca .org/resources/covid-19-telehealth-coverage-policies
Coding Intel: https://codingintel.com telemedicine-and -covid-19-faq/

Billing and Coding

The best reimbursements are for live telemedicine that emulates an outpatient visit and is billed using the same *Current Procedural Terminology* (*CPT*) codes (99201–99215). Previously, Medicare did not allow direct-to-patient visits to be billed, instead requiring a waiver for these services to be provided in underserved areas. During the COVID-19 pandemic, this requirement has been lifted, allowing all patients to be seen from any originating site (eg, the patient's home).

Previously, the CMS had issued guidelines for telehealth visits that required that a physician-patient relationship be established in person prior to conducting telemedicine visits. These guidelines also have been waived for the duration of this public health emergency, allowing physicians to conduct new patient visits via telehealth and bill Medicare. Many commercial payors also are covering new patient visits via telehealth; however, it is best to check the patient's plan first, as some plans may have different requirements or restrictions on allowable *CPT* codes and/or place of service. Prior requirements that physicians at a distant site (ie, the physician providing telemedicine services) be located at a site of clinical care also have been relaxed, thus allowing physicians to be located anywhere while providing services, even for those who are confined to their homes.

In general, commercial payors are covering telehealth visits at 100% of an in-person visit. Although COVID-19–related visits are covered by law, many payors including Aetna, Anthem, Blue Cross Blue Shield, Cigna, Emblem Health, Humana, and United Healthcare have indicated that they will waive all telehealth co-pays for a limited time, including visits not related to COVID-19. At the time of publication, only Aetna has issued a formal policy to this effect, so it is best to check with the insurer.[1,2] However, it is important to note that regional and employer-specific plans may have different policies, so it is best to check with the insurance plans directly to confirm coverage and co-pay status.

Coding should be performed using the usual new/established patient visit codes for outpatients (99201–99215). A place of service (POS) code of 02 previously was used for all telehealth visits; however, the CMS is allowing offices to bill with their usual POS (generally POS 11) and modifier -95 in an updated rule that is active during this public health crisis. This change allows access to higher reimbursements, as POS 02 visits are paid at lower facility fee rates. Commercial insurers have varying policies on POS that are changing, so it is best to check with them individually.

In certain states, store-and-forward services may be billed using a GQ modifier for Medicaid; however, the remote check-in and telephone codes for Medicare do not reimburse well and generally are best avoided if a live telemedicine encounter is possible, as it provides better patient care and direct counseling capabilities, similar to an in-person visit. The CMS has indicated that it is now covering telephone visits (99441-99443) so that providers can contact patients through an audio-only device and bill for the encounter. Generally speaking, telephone visits reimburse the same or more than the virtual check-in codes

From the Icahn School of Medicine at Mount Sinai, New York, New York.
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A tip sheet is available online at www.mdedge.com/dermatology.
Correspondence: George Han, MD, PhD, 1 Gustave L. Levy Pl, Box 1047, New York, NY 10029 (george.han@mountsinai.org).

(G2010/G2012) as long as the telephone encounter is more than 5-minutes long. Digital visits also are available (99421-99423), which include both store-and-forward photographs and a telephone call, but the reimbursements are similar to the telephone-only visit codes.[3]

Although the CMS has relaxed regulations for physicians to provide care across state lines, not all state licensing authorities have adopted similar measures, and the CMS waiver only applies to federally funded programs. It is important to check with state medical licensing authorities to see whether you are authorized to provide care if your patient is not located within the state where you hold your license at the time of the visit. Many states, but not all, have waived this requirement or have set up very expedient ways to apply for telemedicine licenses.

The CMS also released guidance that rules for documentation requirements have been temporarily relaxed,[3] such that visits should be billed at a level of service consistent with either medical decision-making or total time spent by the provider, including face-to-face and non–face-to-face time spent on the patient. (Note: If billing by time, which usually is not advised, use the CMS definitions of time-based coding.) History and physical examination criteria do not have to be met.

Workflow

In general, it is best to maintain your current workflow as much as possible, with a live video encounter replacing only the patient interaction portion of the visit. You will need to maintain an infrastructure for scheduling visits, collecting co-pays (eg, over the telephone prior to the video visit), and documentation/billing.

It is best to have one device for conducting the actual video visit (eg, a laptop, tablet, or smartphone) and a separate device to use for documentation (eg, another device to access the electronic medical record). The CMS has advised that it will not enforce Health Insurance Portability and Accountability Act (HIPAA) rules,[4] allowing physicians to use video conferencing and chat applications such as FaceTime, Skype, or Google Hangouts; however, patient safety is still an issue, and it is imperative to make sure you identify the patient correctly upon starting the visit. During the COVID-19 pandemic, numerous telehealth companies are offering temporary free video conferencing software that is HIPAA compliant, such as Doximity, VSee, Doxy.me, and Medweb. If you are able to go through one of these vendors, you will be able to continue conducting some telemedicine visits after the public health emergency, which may be helpful to your practice.

For some visits, such as acne patients on isotretinoin, you can write for a standing laboratory order that can be drawn at a laboratory center near your patient, and you can perform the counseling via telemedicine. For patients on isotretinoin, iPledge has issued a program update allowing the use of at-home pregnancy tests during the pandemic. The results must be communicated to the provider and documented with a time/date.[5]

Video Visit Tips and Pearls

Make sure to have well-defined parameters about what can be triaged via a single video visit. Suggestions include no total-body skin examinations and a limit of 1 rash or 2 lesions. Provide a disclaimer that it is not always possible to tell whether or not a lesion is concerning via a video visit, and the patient may have to come in for a biopsy at some point.

It is better to overcall via telemedicine than to undercall. Unless something is a very obvious seborrheic keratosis, skin tag, cherry angioma, or other benign lesion, it might be reasonable to tell a patient to come in for further evaluation of a worrisome lesion after things get back to normal. A static photograph from the patient can be helpful so it is clear what lesion is being examined during the current visit. If the patient has a skin cancer at a distant site in the future, there will be no doubt as to what lesion you examined. Having the capability to receive static images from the patient to serve as representative photographs of their chief concern is very helpful before the visit. Often, these images turn out to be better diagnostically than the live video itself, which can be compressed and show inaccurate colors. Some of the telemedicine vendors have this feature built-in, which is preferable. If you are asking patients to send you emails, it is better to have access to a HIPAA-compliant email inbox to avoid any potential issues down the line.

When scheduling a video visit, have your schedulers specifically tell patients that they should be on a high-speed Wi-Fi connection with good lighting in the room. You would be surprised that this is not intuitive for everyone!

Finally, most telemedicine visits are relatively short and to the point. In the beginning, start by scheduling patients every 15 to 20 minutes to allow for technical difficulties, but ultimately plan to be seeing patients at least every 10 minutes—it can be quite efficient!

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