

Telehealth and Plastic Surgery

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WHAT IS TELEHEALTH?

Telemedicine is the use of telecommunications technologies to provide long- distance patient care without in person interaction. This technology can encompass messaging technologies, audio-only communication, email, mobile applications, video- conference platforms, internet-based communication platforms such as patient portals, and remote patient monitoring tools. Specific examples of telemedicine include remote patient tracking (vital signs, tissue oxygenation for free flap monitoring), video- conference based office visits for preoperative and postoperative counseling, and remote expert patient consultations in rural areas via text message or phone encounter. Pre- COVID-19, a systematic review in 2017 documented of the use of telemedicine in plastic surgery and demonstrated that of the 23 studies included, 100% reported a benefit of telemedicine related to improved postoperative monitoring, increased access to expertise in rural settings and cost savings ¹. A more recent study in 2019 found that although patients were initially hesitant to schedule remote telemedicine visits with plastic surgeons, 96% of patients were very satisfied with their experience ². Telemedicine has become increasingly important during COVID-19, with plastic surgeons using a variety of platforms for remote patient communication. The following sections will describe all aspects of telemedicine related to plastic surgery and relevant to members of the American Society of Plastic Surgery (ASPS).

HOW TO TEACH TELEMEDICINE?

Prior to the expansion of telemedicine during the COVID pandemic, telemedicine was part of the medical curriculum in required or elective courses in 84 medical schools in the United States

(about 58% in 2016-2017) ³. No data exists on whether telemedicine has been included in the education of midlevel providers and other physician support staff. Therefore, many trainees and medical staff are unaware of how to conduct a telemedicine visit. Currently, few online courses exist to teach telemedicine. However, with patient consent, observation of telemedicine visits is a good starting point for untrained medical staff and trainees to learn the conduct of an appropriate visit. In addition, courses about telemedicine could be built into the residency curriculum and be required as part of staff onboarding.

Although telemedicine courses specific to plastic surgery are currently not available, the following resources can be used to learn and teach telemedicine:

The American Society of Plastic Surgery has summarized currently available resources for telemedicine visit billing:

<https://www.plasticsurgery.org/for-medical-professionals/covid19-member-resources/telemedicine-billing>

The American Medical Association has published a guidebook to establish a telemedicine practice:

<https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide>

TYPES OF PLATFORMS

There are many different platforms through which telehealth can be delivered. A large number of plastic surgeons have utilized the various forms of telehealth to provide care for both new and established patients, which has increased since the beginning of the pandemic.(4)

Care delivery via telehealth comes in many different forms, but primarily includes visits performed in virtual capacity via synchronous video or by telephone. Asynchronous email or “text” communication, which can be helpful for patients, is not traditionally considered within the realm of telehealth. As a society, ASPS discourages the use of insecure email or text message communication with patients, particularly if confidential information is being discussed. As technology continues to develop and patient acceptance of telehealth increases over time, it is likely that telehealth platforms will improve and additional features will be developed that improve both the surgeon and patient experience.

Within the field of plastic surgery, visual inspection is critical to patient assessment and can be accomplished via video consultation. Virtual video visits may be conducted through a variety of platforms, both those that are freestanding and those that are integrated into the electronic medical record. Any platform used for telehealth should be both secure and HIPAA compliant.(5) It is worth noting that CMS waived these requirements during the COVID pandemic, but one would likely expect these regulations to return in the future. Individual hospital systems and surgeon practices may utilize different platforms (Zoom, Doxy.me, etc) and one should confirm video telehealth policies with your institution and payors.

Virtual telephone visits, by definition, deliver care that would have been rendered in an in-person visit and are not merely telephone calls related to routine care of the patient. Virtual telephone visits may be of greatest utility for patients without the technological capacity for virtual video visits. Although useful, these visits lack the visual feedback that is often essential for patient evaluation within the field of plastic surgery.

BROAD GUIDELINES

To practice medicine, make sure there is a documented patient-physician relationship in place. All histories, exams, proposed treatments must be consistent with traditional in-person standards of care for that particular patient; this includes pre- and post-surgery visits(6).

TELEHEALTH AND HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) plays a vital role in medicine as it protects the patient’s personally identifiable information. Compliance with HIPAA is especially important when conducting telehealth visits. The HIPAA guidelines on telemedicine affect any medical professional or healthcare organization that provides a remote service to patients. Medical providers need to understand that using a dedicated and secured platform is a must as it shields them against HIPAA violations. “Many practices may be surprised by how many cybersecurity controls are available within their existing technologies, but not turned on (7)”. If needed, healthcare providers should review printed guides or ask for phone/email assistance with the setup. Remember, DO NOT leave valuable healthcare information unguarded.

Patients, on another hand, should recognize that maintaining a level of privacy during telehealth visits is essential to mitigating the risk of cyber-security incidents, simply because of the nature of delivering care in a digital setting. Therefore, abstaining from public places and using private areas are the most effective means of addressing cyber-security safeguards.

BILLING AND CODING

Guidance on telehealth reimbursement has been difficult. Perhaps the best guidance was provided by [CMS with Waiver 1135](#) on March 6, 2020. Third party coverage outside of CMS has been checkered but seems to follow CMS recommendations.

CMS

The goal of the waiver was to ensure patients have continued access to care without unduly increasing their risk of contracting COVID-19 and also hopefully decreasing the spread of the disease. Under the waiver, Medicare beneficiaries receive services through telehealth including evaluation and management visits (common office visits), mental health counseling and preventive health screenings. Medicare pays for office, hospital, and other visits furnished via telehealth across the country and including in patient’s places of residence starting March 6, 2020. Of note, however, state licensure laws still apply, and licensure and scope of practice are determined by each state. Providers must have a license in the state where the patient is located, not necessarily where the provider is located. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Prior to this waiver, Medicare would only pay for telehealth on a limited basis: when the person receiving the service is in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of medical facilities for the service. Interestingly though, CMS had made changes in this arena even prior to COVID-19, and in 2019 Medicare started reimbursing for **Virtual Check-Ins**, which are short patient-initiated communications with a

healthcare practitioner. Medicare Part B separately also began paying clinicians for **E-visits**, which are non-face-to-face patient-initiated communications through an online patient portal.

Telehealth Visits: The provider must use an interactive audio and video telecommunications system that permits real-time communication between patient and provider. Usually an established relationship with the patient is required but HHS has suspended any audit of practitioners in this regard to allow for continued care of patients that need it.

Codes:99201-99215 (Telehealth visits in the office/outpatient visits)
G0425-G0427 (Telehealth consultation in the ED or initial inpatient)
G0406-G0408 (Follow up telehealth inpatient or SNFs)

E-visits: A non-face to face communication between an established consenting patient and a provider through an online portal, that can take any format. This visit needs to be patient-initiated.

Codes:99421: Cumulative time over a 7 days period total: 5-10min
99422: Cumulative time over a 7 days period total: 11-20 min
99423: Cumulative time over a 7 days period total: >21 min

Virtual check-in: This is a brief technology (any) based communication between established consenting patient and provider not related to an inpatient visit up to 7 days prior and isn't followed by a visit within 24 hours going forward.

Codes:G2012: 5-10 min of discussion
G2010: Review of Images/video with follow up within 24 hours

Commercial Insurers

Unfortunately, coverage and requirements vary by insurer and by state and the best way to ensure reimbursement is to call the payers directly. Many are reimbursing telemedicine visits similarly to Medicare telemedicine visits. Use the same E&M codes as you would for a Medicare visit.

Modifiers are IMPORTANT!

The **GT** modifier with appropriate Evaluative & Management CPT code must be used for Medicare. It tells Medicare that this was a telemedicine visit.

For a commercial insurance company, the regular E&M CPT code is used together with a **95** modifier. Confirm this though with the payer.

Furthermore, providers must bill the E&M code with *place of service* code **02** along with a **GT** or **95** modifier. Telehealth services not billed with **02** will be denied by the payer. This is true for Medicare or other insurance carriers.

CR and DR are modifiers that may be used by institutional coders to denote a catastrophic/disaster or disaster situation, respectively.

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT): Under this waiver, the HHS Office for Civil Rights (OCR) will exercise discretion and waive penalties for HIPAA violations if providers are working in good faith through everyday communications technologies, such as FaceTime or Skype, during this pandemic(8-12).

DOCUMENTATION

Providers should document the visit as one would normally document, including time-based visits. It is also recommended that one include an attestation as to the telemedicine portion that documents how the visit was performed, between whom (including other participants such as family or a chaperone/nurse) and that consent was obtained. Here is an example from an institution:

This consultation was provided via telemedicine using two-way, real-time interactive telecommunication technology between the patient and the physician. The interactive telecommunication technology included audio and video. The patient was offered telemedicine as an option for care delivery and consented to this option.

Patient location: *** *[include state **and** specify home vs other specific location]*

Provider located at a site approved by *** Medical Center.

Other participants present with provider, with patient's verbal consent:***

Other participants present with patient: ***

The platform used to complete this encounter was *** *[Zoom, Skype, etc.]* through *** *[Epic, doximity, etc.]* unless otherwise specified.

The AMA has developed a Telehealth quick guide, which can be found here: <https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide> (1).

CONTROLLED SUBSTANCE AND TELEHEALTH

In 2008 the Ryan Haight Online Pharmacy Consumer Protection Act, which prohibits dispensing controlled substances via the Internet without a valid prescription, was passed to counter the proliferation of rogue, online pharmacies. This Act, which strongly regulated a provider's ability to prescribe controlled substances, requires providers to conduct an in-person examination before prescribing or otherwise dispensing controlled substances "by means of the Internet." While this Act did limit the ability of a provider to prescribe controlled substances, it did allow for certain exemptions, including the practice of telemedicine.

The COVID-19 pandemic has ushered in a new era of telehealth that is rapidly being adopted by many plastic surgeons. One aspect of the continuum of care that plastic surgeons must confront is the prescribing of controlled substances via telehealth platforms. Although the Ryan Haight Act allowed an exemption to prescribe controlled substances via telemedicine, it was not widely utilized or adopted prior to the COVID-19 pandemic. While a prescription for a controlled substance issued by means of the Internet (including telemedicine) must generally be predicated on an in-person medical evaluation, the Controlled Substances Act contains certain exceptions to

this requirement. One such exception occurred on January 31, 2020, when the Secretary of Health and Human Services (HHS) Alex Azar declared a public health emergency.

On March 16, 2020, Secretary Azar, along with the Acting DEA Administrator, designated that the telemedicine allowance under Title 21 U.S.C Section 802(54)(D) applies to all schedule II-V controlled substances in all areas of the United States. This declaration allows for all DEA-registered health care providers to prescribe schedule II-V controlled substances to patients for whom they have not conducted an in-person evaluation, provided all the following criteria are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and
- The practitioner is acting in accordance with applicable Federal and State laws.

However, it is important to note that if a health care practitioner has previously conducted an in-person medical evaluation of the patient, then that practitioner may issue a prescription for a controlled substance after communicating with a patient via telehealth, regardless of whether a public health emergency has been declared by the Secretary of HHS, provided that the practitioner is acting in the usual course of his/her professional practice, complies with all applicable State and Federal laws, and the prescription is issued for a legitimate medical purpose.

Even with the public health emergency exception, practitioners must comply with both Federal and State laws. For instance, some States prohibit the prescribing of controlled substances via telemedicine, some allow it with restrictions, while others broadly allow it. Additionally, States may announce similar public health emergency exceptions at the State level. Practitioners should review applicable State law restrictions on prescribing controlled substances via telemedicine without a prior in-person examination.

The Ryan Haight Act also provided for an exception in the prescribing of controlled substances via telemedicine under a special registration granted by the US Drug Enforcement Agency (DEA). In 2018 the Support for Patients and Communities Act was signed into law, which required the Justice Department to issue regulations regarding the issuance of special telemedicine registrations to prescribe controlled substances, and the process by which to obtain this special registration. While that registration process has not yet been finalized, one thing is certain – telehealth is here to stay and will become an integral component in the practice of medicine and plastic surgery.

MEDICAL LICENSURE

Generally speaking, if a physician's license to practice medicine is held in the state where the patient is located, then there should not be any additional requirements. However, practicing medicine within one's own state has likely changed dramatically since the beginning of 2020, as many governors have modified existing regulations during the COVID pandemic. These rules may include the establishment of the patient-physician relationship, and rules on prescribing. It is essential to check with your state department of health and/or state medical association for the latest laws and regulations related to telemedicine services.

Practicing telemedicine across state lines can be problematic. Although CMS has temporarily waived requirements that would have required a physician to have a license in the state where the patient is located, most states require physicians to be licensed to practice in the originating site's state, and most states require providers using telehealth technology across state lines to have a valid state license in the state where the patient is located. Similarly, rules for establishing a patient physician relationship across state lines are continuing to evolve. That process will be easier now that the Interstate Medical Licensure Compact is in effect. The compact will facilitate a speedier process with fewer administrative burdens for physicians seeking licensure in multiple states. In addition, state boards can issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine. These types of special licenses allow practice under specified terms.

Generally speaking, it is best practice to carefully review the rules in a physician's originating state, and also in the treating state. Given the rapid expansion of telemedicine services, a number of valuable resources are available. These include, but are not limited to:

- [The Telehealth Resource Centers](#) (TRCs) are funded to serve providers in rural and underserved communities. The TRCs website answers several frequently asked questions about Licensure and Scope of Practice and Credentialing and Licensing.
- To help physicians navigate the process of obtaining a medical license, [the American Medical Association](#) provides up-to-date information on licensure requirements across all states and jurisdictions.
- [The National Council of State Boards of Nursing](#) provides licensure information as well as information about state boards of nursing.
- [The American Telemedicine Association's State Telemedicine Policy Center](#) compiles state-specific information about telemedicine policy.

With regard to the treatment of an existing patient across state lines, it is important to review the individual states' policies regarding this issue. Most importantly, a valid physician-patient relationship must exist before telemedicine services are provided. According to the AMA, this relationship can be established in a few different ways:

- A face-to-face examination – an exam utilizing two-way, real-time audio and visual capabilities, like a videoconference – if a face-to-face encounter would be required for the same service in person;
- A consultation with another physician who has an ongoing relationship with the patient;
- Meeting evidence-based telemedicine practice guidelines developed by major medical specialty societies for establishing a patient-physician relationship.

The American Society of Plastic Surgeon's stance is that cross-state telehealth services may only be provided for established, pre-existing patients. New patients, for whom care is rendered or prescriptions are provided, can only be established via a direct, face-to-face visit, and cannot be established via a virtual consultation.

Many states have modified prescribing rules to allow the prescription of medications across state lines, although only for established patients, and only for a limited amount of time. However, the

gold standard for prescribing across state lines continues to be a DEA Registration Number in the state where the medication is dispersed to the patient.

Similarly, rules for supervision and delegation to Qualified Healthcare Providers (QHP) have changed in 2020. Those health care providers that are currently authorized to furnish services are permitted to furnish distant site telehealth services under the CMS waiver authority during the COVID-19 PHE, including physicians and certain nonphysician practitioners such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish telehealth services, provided that those services are within their scope of practice and consistent with Medicare benefit rules that apply to all services. In general, the requirements for direct supervision have been modified for the duration of the COVID-19 PHE to include the use of a virtual supervisory presence through the use of interactive audio and video telecommunications technology. There are numerous guidelines to follow with regard to the supervision of QHP's across state lines. Again, it is essential to review your particular state's rules regarding supervision and delegation.

LIABILITY, MALPRACTICE CONSIDERATIONS

With regard to Telehealth liability and malpractice concerns, there are two particular areas of concern. These include Cyber Liability, and practice liability.

With an increasing usage of telehealth platforms, exposure of valuable private health information is an associated increasing concern. Areas of vulnerability include the exposure of a confidential patient conversation, network compromise, and/or unlocking access to a system's entire electronic medical record. Practices should review their insurance coverage to confirm they are adequately protected in the event of a cybersecurity attack, and possible business interruption. Strategies to protect large versus small systems are different, but generally involve running continuous versus intermittent vulnerability scans; using multifactor authentication; checking the settings of a practice's videoconferencing platform(s); assessing the security controls and settings in existing and new technologies. Practices must be mindful of using secure point-to-point connections over private high-speed networks that meet the maximum requirements for HIPAA and HITECH compliance. Many insurance providers offer assistance with cyber security concerns, so addressing this with your insurance provider is a valuable first step. Be aware that security risks and regulatory risks overlap in cyberspace.

With regards to malpractice, telemedicine is an increasing portion of healthcare liability claims. The most common reported allegations include missed diagnosis, and the most missed diagnosis was cancer. However, the widespread and rapid deployment of telemedicine platforms since the COVID pandemic is likely to result in claims of types which have not yet been seen, and which will likely take years to emerge. Specific areas of concern include product liability insurance issues for remote-monitoring or therapeutic equipment, and patient abandonment issues given an increased likelihood of breakdown of patient-physician relationships owing to geographic separation. Physicians should further protect their patients and themselves through education in remote exam techniques like the Ottawa knee and ankle rules, or the Roth score for preliminary assessment of shortness of breath, which simply asks the patient to take a deep breath and count out loud to 30—potential COVID-19 patients may be unable to get past seven. Many medical

societies have begun offering education on remote exam techniques specific to their specialties. Finally, check with your malpractice insurance carrier to verify your policy covers care provided via telemedicine. Insurance policies may be complicated by the need for a single policy to cover multiple states, different specialties, states with different individual requirements, and providers with combinations of traditional versus telemedicine practices.

HOW SHOULD SURGEONS CONDUCT THEMSELVES?

When a physician begins a telehealth relationship with a patient, the physician must make sure that there is a documented patient/ physician relationship in place and the physician needs to make sure the patient agrees to a telehealth visit in lieu of an in-person visit (20). All histories / exams/ evaluations and proposed treatments must be consistent with traditional in-person standards of care for that particular patient. The physician and staff need to conduct themselves as if this is an in-person office visit. This includes making sure there are no distractions for either the patient or the physician and HIPAA standards of privacy are maintained. The technology being used must allow for the best decision making. The video/ audio and graphics must be of sufficient quality and should if at all possible allow for linkage to the EMR in real time. Documentation must be consistent with the quality of a standard in-person office visit. Attire and demeanor of the surgeon and staff must always be appropriate. There should be appropriate and legal guidelines for possible recording of the visit by either the patient or the physician. All of these principles must be in place for all telehealth visits regardless of their length or reason for the visit.

CHAPERONES

While plastic surgeons are, for the most part, very familiar with the utility of and necessity for patient chaperones during physical examinations, telemedicine adds another layer of complexity of which providers must be aware. Even though very few publications exist on the use of chaperones, research does indicate that about half of the female population would want a chaperone, and the majority would want to be asked if they prefer to have a chaperone present (21,22). The American Medical Association recommends that providers establish a clear communicated policy that patients are welcome to request a chaperone and further indicates that “in general, [providers should] use a chaperone even when a patient’s trusted companion is present” (23). Chaperone policies not only protect providers from false allegations, but they also protect patients from provider malpractice (24).

Institutions and practices should develop their own medical chaperone policy for the benefit of both patients and clinicians, outlining the importance of and requirement for a medical chaperone for sensitive examinations or procedures for both in-person and telehealth visits. The presence or absence of a medical chaperone should be documented in the patient’s medical record.

Providers must realize that a ‘digital’ interaction with a patient carries the same risk as in person interaction even though the risk may be perceived as less. The AMA Code of Medical Ethics Opinions on Patient-Physician Relationships indicates that “physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions,” including chaperone standards (25). Consequently, the minimal recommendation is that the patient should be asked whether they would like a chaperone. However, the preferable recommendation is that you, as a provider have a chaperone with you

when physically examining the patient every time. The chaperone can be physically present with the provider or the patient, or the chaperone can join. All telemedicine visits should be patient initiated with appropriate education and consent. Documentation of who participated in the visit is also important.

CONCLUSION

The COVID-19 Pandemic caused many abrupt changes in the way medicine – and particularly Plastic Surgery - has been traditionally practiced. As we adapt as a society to these changes and adjust to regional and temporal differences in pandemic management, telemedicine has been and will likely continue to be a helpful tool. Like any tool, familiarity with its utility and precautions is important. Used strategically, telemedicine can be used to safely and effectively deliver patient care.

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