Telehealth Nuts and Bolts for Eye Care

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1. All information was current at time it was prepared
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Outline

- Definitions
- Rules and Ethics and Legal Issues for Telehealth
  - AOA Criteria
  - NCSBO Criteria
  - Past Legal Precedent
- Goals and Guidelines for Telehealth
- COVID-19 Rules vs Post COVID-19 Rules possible
- Patient education
- Staffing education/staff roles
- Considerations for Telehealth
- Telehealth Visit Etiquette
- Visit Flow
- Possible clinical care and Limits of Telehealth Care
- Technology Available for Use
- Use of technician/hybrid visits
- Platform choice considerations
- Other considerations
- Coding and Billing
- Resources

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What is Telehealth

- Synchronous Telemedicine
- Asynchronous Telemedicine
- Non Face-to-Face Telehealth
  - Virtual Check Ins
  - E-visits
  - Telephone Services
  - Telehealth Services

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Telehealth
Delivering Care at a Distance

Telemedicine
Practicing Medicine at a Distance

Telehealth:
The Health Resources Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications."3

Telemedicine in optometry:
The American Optometric Association defines telemedicine in optometry as the provision of eye, adnexa, visual system and related systemic health care services (collectively "eye, health, and vision services"). Asynchronous and synchronous technologies can be used to provide this type of care including videoconferencing, internet-based services, store-and-forward imaging, streaming media, and terrestrial and wireless communications

https://www.aoa.org/AOA/Documents/Advocacy/position%20statements/AOA_Policy_Telehealth.pdf

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AOA CRITERIA FOR ENSURING HIGH QUALITY TELEMEDICINE IN OPTOMETRY

Overall Principle of Telemedicine

- Ensures existing standard of care be met (No matter care setting - in person to telehealth to combination visits)
- High-quality
- Contributes to care coordination
- Protects and promotes doctor-patient relationship
- Complies with state licensure and other legal requirements
- Maintains patient choice and transparency, and protects patient privacy

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AOA CRITERIA FOR ENSURING HIGH QUALITY TELEMEDICINE IN OPTOMETRY

- Doctors may not waive their obligation or require patients to waive their right to receive the standard of care
- Payors may not require either doctor or patient waive right to receive the standard of care
- Establish/maintain fundamental elements of the doctor-patient relationship
- Physicians must act as advocates on behalf of patient with obligation to discuss necessary/appropriate treatment alternatives, and to fully inform the patient of all treatment options
- Physicians must ensure all protected health/personal information is confidential
- Patients must consent to receive telemedicine in optometry
- Patient must understand their right to choose (at any point in the care continuum) in-person eye, health, and vision services

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AOA CRITERIA FOR ENSURING HIGH QUALITY TELEMEDICINE IN OPTOMETRY

In-person care is the gold standard for comprehensive eye exam/prescription of glasses or contact lenses

- Remote patient monitoring may be appropriate for:
  1. Data acquisition
  2. Patient communication
  3. Confirmation of expected therapeutic results
  4. Confirmation of stability/or homeostasis
  5. Assessing changes in previously diagnosed chronic conditions
- SOMETIMES appropriate for establishing doctor-patient relationship for an initial diagnosis

BUT

- Should not be used to replace partial or entire categories of care available in-person where doctor-patient relationship is strengthened through personal face-to-face interactions

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AOA Telemedicine Guidelines – Licensure

- ODs delivering telemedicine in optometry must be licensed in state where patient receives care
- ODs must abide by that state's licensure laws and regulations
- If requested, must promptly provide in-person care or refer for an in-person visit to another qualified physician for diagnosis and/or care
- Referrals must occur in an appropriate timeframe

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AOA Telehealth Guidelines - Documentation

- All appropriately relevant health history must be collected
- Appropriate health records should be available prior to or at the time of telehealth encounter
- Must have good understanding of culture, health care infrastructure, resources etc. at originating site (patient site)
- Must properly document encounters in health record
  - Should be available at remote site and at originating site
  - Be electronically or physically available to patient
- Adhere to standard of care with regard to care coordination with additional health care providers
  - Health records must be clear particularly regarding diagnoses, test results, and medication changes

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AOA Telehealth Guidelines-

Without Established Doctor-Patient Relationship

Without an existing doctor-patient relationship:

- **MUST perform comprehensive eye exam - including all the elements of comprehensive exam in order to meet Standard of Care**
- Without a comprehensive exam, cannot offer prescriptions for eyeglasses or contact lenses
- Standard of care cannot be delivered independently by telemedicine

Any doctor of optometry who offers a prescription under such circumstances would be in violation of their ethical obligations and duty of care

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AOA Telehealth Guidelines-
Be Aware of Technology Limitations

- Direct-to-patient eye and vision-related applications, based on current technologies and uses, **cannot replace or replicate in-person comprehensive eye examination provided in-person by an eye doctor**
- Eye health portion of a comprehensive eye examination and the refractive portion of a comprehensive eye exam, based on current technologies and uses, **cannot be replaced or replicated by direct-to-patient eye and vision-related applications**
- **Screenings cannot be used to diagnosis or treat** conditions. Or used to replace in person comprehensive eye examination

BEWARE — There are programs and instrumentation available BUT they can only provide screening tests NOT billable medical testing — BEWARE

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AOA Telehealth Guidelines-
Be Aware of Technology Limitations

- Refractive tests, including online vision tests and other mobile vision-related applications, **cannot be, based on current technologies and uses, used to provide a refractive diagnosis and/or an eyeglass or contact lens prescription**
- Photographs obtained by patients, their family members, or their friends outside of a clinical setting **may not be of adequate quality, or may not include the information needed to make an accurate diagnosis**
- Doctors must ensure adherence to their state laws and regulations

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NC State Board of Optometry Position

- Telemedicine is a tool and not separate field of optometry, nor does telemedicine alter scope of practice of North Carolina-licensed optometrists
- Accordingly, Board cautions those subject to its jurisdiction and control that **there is no separate or different scope of practice or standard of care applicable to those who practice optometry via telemedicine within this state or to those optometrists located outside North Carolina who diagnose and treat via telemedicine patients located within this state**

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NC State Board of Optometry Position

- Board considers "telemedicine" to be the interaction between licensed optometrist in one physical location and optometrist's patient located in different physical location, accomplished via audio-visual link, imaging, telephone, or other appropriate forms of electronic communication and/or technology used to allow or assist optometrist in providing care to patient
- **Accordingly, telemedicine in the field of optometry, if employed in appropriate manner and circumstances, can provide significant benefits, among them increased patient access to health care, increased availability of patient records, and reduced costs.**
- **However**, in order to fulfill its mandate to protect the citizens of this State, the Board also must consider patient safety and wellbeing in interpreting statutes and policies historically intended to apply to in-person provision of optometric care and applying those statutes and policies to new delivery models involving telemedicine technologies

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NC State Board of Optometry Position

To provide comprehensive care, establishing such relationship includes, but is not limited to, the following:

- See patient in established office at least once prior to telehealth
- If not possible to see patient prior, OD MUST take time to ensure proper history, patient conditions and assess needs of patient prior to diagnosis and Treatment
- The optometrist should provide comprehensive care to patient, not just screen patients for presence or absence of abnormal conditions of or pathology of the eye or adnexa. Becomes that patient's primary eye care provider
- Must verify patient identity per HIPAA rules
- Obtain and review entire patient history
- Must identify to patient who you are and credentials with photo displayed in image

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NC State Board of Optometry Position

- Provide patient direct contact with OD
- Maintain appropriate patient records and documentation
- Explain risks and benefits of telehealth
- Patient welfare is first and primary
- Not excused from performing appropriate examination, evaluation, and assessment of patient's condition by virtue of patient's physical remoteness from optometrist
- Must conduct appropriate assessment of ocular health and visual status of patient

Board standard of care does not permit an examination consisting solely of objective refractive data or information generated by an automated testing device such as an autorefractor in order to establish a medical diagnosis or to establish refractive error.

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NC State Board of Optometry Position

- Prescription based solely on a patient's responses to a written/online questionnaire does not meet Standard of Care
- Optometrist must maintain equipment and instruments in his/her office at all times adequate to assure proper and complete examination of patients

Practice of optometry occurs both where patient is located and where optometrist providing professional services is located.
In order for an optometrist to provide professional optometric services to person located in North Carolina that optometrist must be licensed by this Board

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NC State Board of Optometry Position

North Carolina licensees who wish to treat patients located outside North Carolina by utilizing telemedicine should know both that this Board has oversight of such practice and that other states' board(s) of optometry may take the position that such constitutes the practice of optometry in their respective states, and accordingly such boards also may require licensure in their states as a prerequisite

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Legal Issues for Telehealth

- Legal Concept for Duty of Care
  - Both Patient and Doctor have to agree to relationship
  - Historically a physical examination was key
- Without the relationship then No Duty
- No duty = No right to Treat & No right to prescribe & No right to bill
- Can establish doctor-patient relationship virtually but rules vary by state- typically audio-visual interaction must be used and is more than an informal meeting

DOJ-OIG-HHS Recent Case Sept 2020
$4.5 Billion in telehealth fraud >300 Defendants
"Telemedicine can foster efficient, high-quality care when practiced appropriately and lawfully.
Unfortunately, bad actors attempt to abuse telemedicine services and leverage aggressive marketing techniques to mislead beneficiaries about their health care needs and bill the government for illegitimate services,"

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Legal Issues for Telehealth

Hord v US - 4th Circuit - April 28, 1999
Treating MD refers to another provider for cancer treatment
New MD accepts Transfer Patient accepts care
Lawsuit: Claimed no physical exam thus no relationship
Court ruled: MD accepted referral and Patient accepted treatment
Thus relationship in absence of physical examination

Wheeler v. Yettie Kersting Hospital Texas 1993
Nurse call MD asking if patient stable for transport
MD did not talk to patient but approved transport
Court ruled MD–patient relationship established due to care decision made Thus Duty existed

Hill by Burston v Kokosky - Michigan - 1990
MD contacted another MD to discuss treatment options
Ruling: Consultation peer to peer does not create a duty of care
Olive v. Brock – Alabama - 1977
Curbside consultation does not establish patient doctor relationship

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Legal Issues for Telehealth

Tumblin v Ball-Incon Glass Packaging – SC – 1996
MD hired by company to perform pre-employment physical
During evaluation, HTN noted, told to see PCP
Patient had stroke and died –family sued hired MD
No trial- judge directed verdict – No duty existed

White v Harris – Vermont – 2011
Psychiatrist in clinical trial - one time interaction with patient and ended in writing – no duty was established
Court – Distance Care Consult Occurred
Consult provided diagnostic impressions/treatment recommendations to patient care team
Thus- limited doctor-patient relationship sufficient to establish Duty of Due Care

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Define Goals for Telehealth Program

- Staff efficiency
- Patient compliance/convenience
- Improving access to care
- Streamlining your schedule
- Address "downtime issues"
- Examine the value to patients, staff, practice

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Considerations for Telehealth Use

- Access to Care
- Chronic Care Management
- Post Acute Care Management
- Triage for emergency calls
- Many channels for communications

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Myths about Telehealth

- Patient don't want it - COVID-19 has taught us they love it.
- Poorer care than in person – maybe but better than no care

Reality

An **early analysis** of COVID-19 telehealth utilization published in May 2020 found ~20 percent of all Medicare, Medicaid, and commercial outpatient, office, and home healthcare spending could transition to virtual care = ~$250 billion worth of care

- One study estimates that 35 percent of home healthcare, 24 percent of office visits, and 20 percent of emergency department visits could be virtualized

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Reasons Patient Give for Telehealth

JD Power Survey: Top 12 reasons for using telehealth - 2020 (2019 ranking/percentages in parentheses)

1. Convenience - 51 percent (1, 64 percent)
2. Safety - 46 percent (12, 13 percent)
3. Speed – ability to receive care quickly - 44 percent (2, 53 percent)
4. Quality care - 30 percent (6, 25 percent)
5. Condition covered by telehealth visit - 28 percent (7, 22 percent)
6. Ease of access to health information - 27 percent (3, 34 percent)
7. Convenient communication channels - 26 percent (4, 33 percent)
8. Lower overall cost - 23 percent (5, 30 percent)
9. Difficult to travel to medical office - 21 percent (7, 20 percent)
10. Recommendation - 19 percent (7, 20 percent)
11. Reputation - 19 percent (11, 14 percent)
12. Past experience -17 percent (9, 19 percent)

https://www.jdpower.com/business/healthcare/us-telehealth-satisfaction-study

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Telehealth Post COVID-19

- Who will allow to offer what services
- When will services be allowed
- What payers are on board
- What payers excluding eye care
- Rules are in flux currently
- But telehealth here to stay in some forms

Pre-COVID-19 PHE, Telehealth use was limited
Medicare rules very strict and limiting

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Rules Predicted in NC

- **Medicare** – will be allowed but stricter rules, HIPAA compliance in particular
- **Medicaid** – will be allowed maybe but tighter rules, HIPAA compliance required
- **Private** – Already pushing telehealth and televisits but with own providers?
- **Vision Plans** – Who knows? Not yet announced

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Third Party Payment post COVID-19

- CMS intends to extend some Telehealth service changes made during PHE
- Private payors must decide if and how to extend this coverage
- Many unknowns but doubtful telehealth service coverage will revert to pre-PHE restrictions
- Must know and understand each payors policies going forward
- Must develop a policy for collection of copays and deductibles pre-visit
- Must understand HIPAA policies, patient consent policies and all rule changes post-PHE

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CMS Payment – Telehealth Claims

- > 12.1 million beneficiaries received a telehealth service mid-March 2020 - mid-August 2020 (Medicare fee-for-service claims data) (~ 36% of Medicare Beneficiaries)
- Medicaid/CHIP data - telehealth utilization increased > 2,600 % March and June 2020 (>34.5 million services)
- CMS Administrator (Seema Verma) indicated Medicare telehealth expansions implemented during PHE - including telehealth payments for non-rural patients and in patient homes, may be made permanent
- Possible Post-pandemic considerations:
  - Telehealth rates similar to hospital professional rates
  - Level of resources involved in telehealth visits considered in rate setting
  - Patient safety and clinical appropriateness
  - Healthcare fraud and Medicare program integrity
    - Providers offering shorter telehealth visits to maximize payment
    - Providers billing more visits than are possible in a day

https://revcycleintelligence.com/news/telehealth-billing-increased-8336-from-april-2019-to-april-2020
https://revcycleintelligence.com/news/cms-provides-medicare-reimbursement-for-more-telehealth-during-phe

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Third Party Payment – Telehealth Claims

FAIR Health:

Telehealth claim increased by 8,336% April 2019 to April 2020

Telehealth claim nearly doubled 4,347% March 2019 to March 2020

Privately insured population

Excluded Medicare and Medicaid claims

https://revcycleintelligence.com/news/telehealth-billing-increased-8336-from-april-2019-to-april-2020

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Educate Everyone

- Staff on Why
- Educate Patients on Benefits
- Provide options for patients
  - Telemedicine Visits
  - Virtual Check ins
  - Portal Access for questions

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Staffing Role

- Scheduling properly
- Patient information intake
- Ensuring timing of visit
- Ensuring patient set up
- Good connectivity vital
- Staff role for options when technology fails

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Staffing for Telehealth Coordination

- Consider who in office can coordinate properly
- Internal skills first
- External skills if necessary
- Obtain training for platform
- Obtain training for rules/guidelines for appropriate patient visits

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Office Policies Established

- **Identify** priority patients for telehealth
- **Educate** patients using a script
- **Convert** patients to telehealth
- **Visit** by telehealth

…but have a back-up plan for when technology fails

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Visit Assumptions and Etiquette

ASSUME and BE AWARE

- Always on camera – reactions & professional
- Avoid candid camera moments
- Dress appropriately
- Shot background – care with distractions
- Body language –
- Logistics and radar
- Help patients hear
- Connect with patient – eye contact
- Clean – Crisp- Clear

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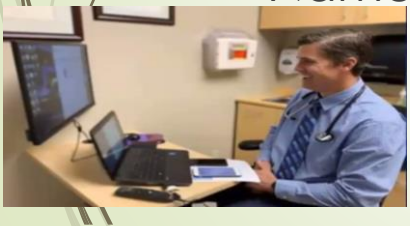
Actual Visit Considerations

NO!!

- Dress – business causal
  - No pjs or sweat pants
  - No loud or distracting clothing
  - No noisy jewelry
  - No baseball caps
- Name tag and credentials displayed

YES!!



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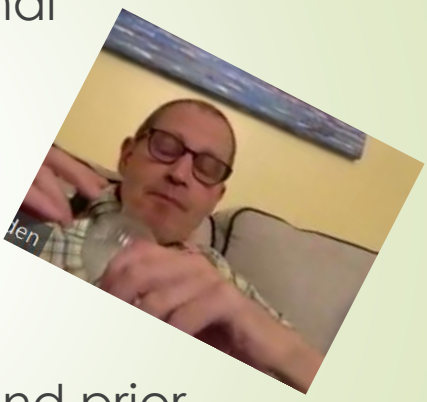
Actual Visit Considerations

- Background setting -Professional
  - Not from recliner
  - Not in distracted situation
  - No eating or drinking
- Background noise/privacy
  - No music or TV noise
  - View yourself and background prior
- Lighting appropriate – Avoid Shadows



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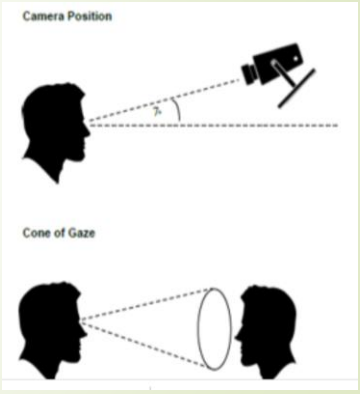
Posture

- Eye level with camera- do NOT look down on patient
- Know where camera is
- Avoid set up with cell phone video off to side
- Sitting up straight- feet on ground
- Avoid excess motion- hand gestures low desk level
- Monitor facial reactions
- Don't cross arms



Above ALL -Do NOT be a "Jeffrey Toobin"

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Assurance to Patient

- Private
- Who is present with you- tech etc
- Know who is present with patient
- Ensure patient has privacy and is comfortable
- Tell patient you may be writing or reviewing record during conversation
- Avoid looking at screen/notes and NOT patient

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Visit Flow

- Schedule
- Patient link and training
- Workflow
  - Tech to call patient for history prior
  - Patient to complete on line forms
  - Need to clearly review all prior to visit into HER
  - Patient consent and information about telehealth
  - Documentation, same as office but clearly document telehealth

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Scheduling

- Interspersed throughout day
- Block of time for telehealth
  - Morning
  - Lunch
  - Late afternoon
- Doctor at home for visits (half day? Or several?)
- In between patients (staff cleaning/PPE etc)
- Care with Telehealth wait times- no more than 5 minutes ideal

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Encourage Patients to Fully Participate

And the DrFirst survey says:

- 21 percent checking social media or eating meal or snack
- 19 percent playing video game
- 18 percent were exercising
- 11 percent were smoking cigarette
- 10 percent were driving a car
- 9 percent were having an alcoholic beverage

- 73 percent of men reported multitasking
- 39 percent of women reported multitasking

https://mhealthintelligence.com/news/telehealth-faces-new-challenges-surfing-snacking-and-social-hour?eid=CXTEL000000580813&elqCampaignId=16633&utm_source=nl&utm_medium=email&utm_campaign=newsletter&elqTrackId=2e4161e2141a4a40a57b32c9ce34e701&elq=5b0f07d811d748cc8ab3025de1f62ec6&elqaid=17333&elqat=1&elqCampaignId=16633

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Understand/state "Order of business"

- Staff connect with patient using audio-video connections
- Staff document patient consent
- Staff complete medical history/history of present illness (HPI), medical record updates
- Staff or doctor can perform testing required as possible
- Provide the patient with flow guidance
- Doctor enters call
- Start timer for visit
- Informed them of your surroundings and privacy
- Start doctor portion of visit

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Clinically Appropriate Care

- Glaucoma Patient Compliance
- Dry Eye Disease Patient follow up
- Acute infection follow ups
- ARMD check ins
- Other types of care

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What Telehealth Can and Cannot Do

Cannot do with Telehealth

- Deep anterior seg examinations
- Posterior examinations
- IOP checks –
  - ? iCare Tonometer and the Sensimed Triggerfish contact lens

Can do with Telehealth

- Anterior to some extent
- Pupils
- EOM
- ?Self VF?
- History symptoms

For virtual Visits:
Records must be kept BUT Advice to NOT RECORD any telehealth or audio visit

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Clinically Appropriate Care

- Red eyes
- Potential Conjunctivitis
- Subconjunctival Hemorrhages
- Dry eye disease
- Blepharitis
- Pinquecula/Pterygium
- Medication monitoring
- Lid lumps and bumps – Chalazion, Hordeolum
- External adnexa

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Visual Acuity

- Something to cover the eye – tissue behing glass lens, hand, etc
- Well-lighted room with 10 feet for distance
- Correct testing chart.
  - largest letter at top of chart - just under an inch (23 millimeters) tall
- Patient to measure 10 feet -stand or sit that distance from chart
- Chart at eye level of patient

Find Printable Adult and Child eye charts, Tumbling E charts and further instructions at:
https://www.aao.org/eye-health/tips-prevention/home-eye-test-children-adults

- Other "gross acuity" testing – words on TV, calendar across room etc

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Visual acuity	**Infant/toddler**
	Check fixate and follow with parent or sibling holding toy
	Screen share age-appropriate video and observe the child's fixation behavior
	Observe differences in response to occlusion
	Verbal child
	Ask child to describe items around the room with both eyes and each eye individually
	Older child/teenager/adult
	Ask patient to read items across the room and give a report of their relative visual acuity
	Screen share a visual acuity chart to determine relative acuity between eyes
	Downloadable American Academy of Ophthalmology recommends Verana Vision Test for adults

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Amsler Grid

- Printable amsler grids with instructions available

https://www.aao.org/Assets/6684654c-b054-454e-8e66-a1b2ec6d8234/637207568125830000/amsler-grid-pdf?inline=1

- Take home amsler grid from office
- Mobil app amsler grid

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IOP

- iCare Tonometer (patient buy or rent)
- Sensimed Triggerfish contact lens
  - Remote monitoring device that allows observation of fluctuations in IOP pattern
    - Monitor progression of glaucoma.
    - Transmit data wirelessly to device that records pressure changes and to Office for analysis
    - In research: IOL to measure and transmit IOP for continuous remote monitoring of IOP
- Finger tensions?
- Offer "parking lot" test with tech measuring while patient in car

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Other "Testing" Abilities

- Pupils
- Eye movements and alignment
- Pen light anterior segment with camera
- Patient selfie images (are not separately billable)
- Conduct medical discussion
  - including questions from the patient and family
- Document time length of visit

An external photo taken with an iPhone 8 to show the quality of the image you can get with a video visit.

Visit can allow basic psychologic and neurologic, external adnexal, pupil, motility, alignment, anterior segment, iris, and corneal light reflexes –need patient is well lit area-often bathroom lighting is best
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7191296/

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Color vision	Subjective red desaturation
Confrontational visual field testing	Best when the patient is using a computer rather than mobile phone for a wide display
	Attempt patient self-administration (subjective)
	Perform counting fingers or double simultaneous stimulation tasks
	Present of Amsler grid through video camera or screen share
Pupils	Observe
	Enhance with a flashlight if needed
	Relative afferent pupillary defect testing is difficult; findings can be confounded by accommodation to the screen
Ocular motility	Utilize a parent or sibling to move a toy for young children
	Ask the patient to look in all directions of gaze
	Consider Doll's head maneuvers while the child views themselves or a movie on the video visit screen
	Ask the patient to conduct smooth pursuit and saccadic eye movements
Eye alignment	Observe the corneal light reflex in different directions of gaze
	Ask the parent or the patient to assist with cover–uncover and cross-cover testing and estimate the deviation
	Ask the patient to describe the relative separation in diplopic images in directions of gaze

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External examination	Observe under appropriate lighting
	Check for erythema, eyelid position and movement, margin-to-reflex distance, symmetry (or asymmetry) of skin folds
Eyelids and adnexa	Observe by bringing the eye close to the camera
	Ask the patient to lift the lids and look down to observe lacrimal gland
	Ask the patient to evert the lower eyelids by pulling down
Anterior segment	Observe
	Enhance observation with external lighting if needed; light reflex testing can show health of ocular surface
	Side illumination (as for Rizzuti sign in keratoconus) gives views into the anterior chamber and at the lens

Ptosis	Triage, diagnosis, and initiation of treatment plan
	Postsurgical evaluation of healing
Thyroid eye disease	Follow-up evaluation of ocular motility and proptosis

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COMPREHENSIVE OPHTHALMOLOGY	
Blepharitis	Triage, diagnosis, and initiation of conservative therapy in a patient with eye irritation
	Evaluation of response to conservative therapy
Chalazion	Triage, diagnosis, and initiation of conservative therapy
	Evaluation of response to conservative therapy
Dry eye syndrome	Triage, diagnosis, and initiation of conservative therapy in a patient with eye irritation
	Evaluation of response to conservative therapy
Conjunctival laceration	Diagnosis and determination of necessity of repair
	Follow-up evaluation to monitor resolution of pain, redness, irritation, and healing
Corneal abrasion	Evaluate for corneal opacification that might signify infection
	Follow-up evaluation to monitor resolution of pain, redness, irritation, and healing
	Follow-up evaluation of corneal light reflex to see whether it is sharp (and abrasion healed)

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CORNEA	
Stable post-penetrating keratoplasty patient	Evaluation of medication adherence and subjective vision
Allergic, viral, or bacterial conjunctivitis	Triage, diagnosis, and initiation of treatment
	Follow-up evaluation to monitor response to treatment

GLAUCOMA	
Stable glaucoma patient	Evaluation of symptoms with self-administered confrontation visual fields
	Evaluation of medication adherence and subjective vision
Counseling of active glaucoma patient	In-person visit for intraocular pressure check and visual field evaluation followed by review of results virtually to minimize contact
Eye redness	Evaluation of adverse medication reaction
	Counseling of how to change administration

OCULOPLASTICS	
Preseptal cellulitis	Triage, diagnosis, and initiation of treatment
	Follow-up evaluation of treatment efficacy
Orbital cellulitis	Follow-up evaluation of treatment efficacy after discharge
Eyelid lesion	Triage, diagnosis, and initiation of treatment
	Postsurgical evaluation of healing and review of pathology

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NEURO-OPHTHALMOLOGY	
Cranial nerve palsy/diplopia	Triage, diagnosis, and initiation of next steps in treatment
Idiopathic intracranial hypertension	Follow-up evaluation for adherence to treatment plan and recurrence/worsening of symptoms
Optic neuropathy	Follow-up evaluation of subjective visual function including acuity, color, and visual field
	Review ancillary testing including fundus photography, OCT, and automated perimetry
Nystagmus	Triage, diagnosis, and initiation of next steps in evaluation and treatment
Anisocoria	Triage, diagnosis, and initiation of next steps in evaluation
Strabismus	Triage, diagnosis, and initiation of next steps in evaluation and treatment
	Follow-up evaluation of treatment efficacy (prism glasses or strabismus surgery)

Virtual Visits in Ophthalmology: Timely Advice for Implementation During the COVID-19 Public Health Crisis. Telemedicine and e-Health VOL. 26 NO. 9 SEPTEMBER 2020 1113-7.

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RETINA	
Flashes and floaters	Triage to understand the nature and suggest in-person evaluation if needed
	Consider patient-administered confrontation visual field testing
Macular degeneration	Review ancillary testing including fundus photography, OCT, and FA
	Amsler grid testing done through a screen share to the patient
Diabetic retinopathy	Review ancillary testing including fundus photography, OCT, and FA
	Counsel on blood glucose monitoring and control
UVEITIS	
Iritis	Follow-up to evaluate for redness and photophobia

FA, fluorescein angiography; OCT, optical coherence tomography.

Virtual Visits in Ophthalmology: Timely Advice for Implementation During the COVID-19 Public Health Crisis. Telemedicine and e-Health VOL. 26 NO. 9 SEPTEMBER 2020 1113-7.

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Care Examples

- Chief Complaint: redness, itching, burning, tearing, or eyelid conditions – telehealth
- Follow up for glaucoma patient to check for compliance
  - Inquire about medication refill needs
  - Verify not having side effects and no ocular complaints
- Follow up on macular degeneration patients
  - Ensure compliance with Amsler grid use
  - Ensure compliance for use of AREDS supplements
  - Inquire about vision changes or other complaints

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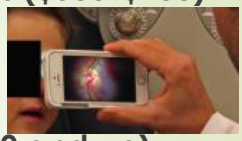
New Devices but Costly

- **Smartphone Attachment Portable Retinal Imaging Systems ($300-$400)**
  Attachment to record and transmit high quality still and video
  Potential for patient self use?



- **Portable Vision, Color and Contrast Sensitivity Devices ($60 and up)**
  Attachments for smart phones and stand alone devices available on open market

- **iCare Tonometer and the Sensimed Triggerfish contact lens ($500 and up)**
  At home IOP testing

Expect many new devices to be developedgoing forward

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Mobil Phone/Computer Applications

- Several Applications for Apple and Android
  - Screening test for vision
  - Screening tests for color perception, astigmatism and eye dominance
- Computer Screening Tests
  - Acuity screening distance
  - Astigmatism screening
  - Contrast sensitivity screening
  - Near vision screening

IMPORTANT:
These are SCREENING TESTS only
Provide some idea of visual function

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Patient Flow – Even in Office

- Ditch the waiting room
- Get history on line, via portal, phone calls
- Wait in parking lot until time
- Call/Text patient when can come into office
- Bring patient into office just when seeing doctor

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Hybrid Visit

- Part of visit in-person and part remotely during single day
- Patient come to office for imaging or testing only
- Telehealth for remote visit completion
- Could Include
  - Drive-Through IOP Visit – tech takes IOP at car side
  - Patient in office for imaging only
  - In office vision and IOP only visit – complete visit via telehealth
  - Tech to patient home for IOP/vision – complete visit via telehealth

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Choosing Platform

- Request demonstrations of how platform works
- Understand workflows, clinical discussions
- Availability for continuing training
- How to offer to patients and to whom
- Platform specific - What patients are appropriate?
- Platform specific - What patients must be seen in person?

Keep Patient Use in Mind
Patient use end of platform IMPORTANT

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Choosing Platforms

- HIPAA Guidelines- overview after pandemic
- COVID-waivers going away
- Cloud based?
- Ease of Connectivity
- What is video platform?
- Mobile applications
- Technical Support available
- Costs

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Platform Considerations

- Usable anytime from anywhere
- Respect doctor's time and privacy
- Be able to communicate with patients as necessary
- Ba able to maintain record of communication
- Be able to add record to electronic health record later
- Be private, secure, and HIPAA-compliant so no concerns about privacy loss
- Ease of Platform use
- Platform Security
- Terms of Service
- Licensing Considerations
- Utilization and Return on Investment
- Real-time telemedicine visits should use an app/link specifically designed for that purpose

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Platform Considerations

Approach	Pros	Cons
EHR + Patient Portal Integration	• One login for care teams • Synchronized e-Checkin with consents, insurance verification, co-pay collection, etc. • More time to share link • Promotes use of portal for its other features (self-scheduling, med refills, results, etc.)	• Extra steps = more chances for things to go wrong (email address, portal account, proxy access for caregivers/parents, navigation, Vidyo bugs, etc.)
Stand alone Platform	• Patient: Simple. Just need a smartphone and click on a link. • Provider: Create virtual room in <30 sec., share with others quickly. • Nice back up before resorting to phone-only visit.	• Consents and other compliance items handled separately. • Outside of normal EHR workflows

(Interpreters can join virtually be sure to schedule.)

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HIPAA, Platforms, Privacy

- Many HIPAA Rules waiver during PHE but will NOT continue
- Platforms will have to meet all HIPAA rules for privacy
- HIPAA compliance
- Office of the National Coordinator for Health Information Technology (ONC) web page Health IT privacy and security resources for providers

https://www.healthit.gov/topic/privacy-security-and-hipaa/health-it-privacy-and-security-resources-providers

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Choosing Platform

EyecareLive -

- Cloud-based portal
  - visual acuity testing
  - dry eye questionnaires.
- Requires patient to download app
- Doctors must use computer with video capabilities.
  - EyecareLive does not have an app yet for the doctor's side, but this is planned for the future

Doxy.me

- Does not require patient to download anything
- Basic service for free with personalized room URL
- Doctor can connect from notebook, computer, tablet, or mobile phone – No app
- No eye care specific testing visual acuity or anything eye care specific

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Choosing Platform

- **Presence platform** provides a central portal where patients can schedule a telemedicine visit with their provider.
  - **Telemedicine platform available to all health care providers in North Carolina at no charge, until the COVID-19 pandemic abates**
- **Doximity** Largest > 70% of US doctors and 45% of all NPs/PA are members
  - Doximity Dialer Video is first telemedicine offering - enables doctors to video call patients with single - encrypted connection - HIPAA comliant on their own iOS or Android smartphone – No additional setup for doctors or patients
- **CheckedUp** specialty medicine digital point of care company, has announced the launch of CheckedUp Virtual Visits

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Vendor Name	Product Name	Video Conferencing	Patient cost: Pay per visit cost	White Label	Vendor offers providers	Client providers permitted to use software	Integration with EMR	Supports on demand visits	Supports scheduled visits	Data reporting capabilities	Multi-party video
AMD Global Telemedicine	Connect n Care	X	X	X		X	eprescribe	X	X	X	X
Amwell		X	X	X	X	X	X	X	X	X	X
BlueJeans		X	O	O	O	X			X	X	X
Bright MD	Smart Exam	O			O	X		X	O	X	O
Carena		X	X	X	X	X	X	X	O	X	O
Caregility	iConsult	X	O				EPIC only	X		X	X
CirrusMD		O			X						
Doctor on Demand		X			X	X		X	X		
Doxy.me		X		X	O	X	O	X	X	X	O
Evisit	eVisit Express	X	X		O	X	X	X	X	X	X
Fireflyhealth		X	X		X	O			X		
Galileo		O	Subscription	O	X	O	O	O	X	O	O
Insight		X	X	O	X	O	X	X	X	X	O
InTouch	See Teladoc										
Livi	Only international										
MeMD		X	X	X	X	O	O	X	O	X	O
Medhealth2go		X	Coming soon		O	X			X	X	
Microsoft Teams	Andor Platform &Teams	X				X		X	X	X	X
MyOnCallDoc		X	X	X	X	X	O	X	X	O	O
MDLive		X	X	X	X	X		X	X	X	O
Second Opinion		O	X	X	X	X	O	O	X	O	O
SnapMD		X	X	X	X	X	X	X	X	X	O
Synzi		X	O	X	O	X	X	X	X	X	X
Teladoc	InTouch/Solo/	X	X	X	X	X	X	X	X	X	X
Tyto Care		X	X	X	X	X	X	X	O	X	O
VitelNet	vCare Command	X			O	X	X	X	X	X	X
Zipnosis		X	X	X	O	X	X	X	X	X	X
98Point6		Text based			X	O					

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Nuance DAX
-Dragon Ambient Experience

Increases efficiency
Streamlines documentation
Single platform fo all clinical environments

Automated
Conversation with patient
To
Clinical Notes
Integrates with several current EHR

Produces clinical notes in few hours
Clinician reviews
Becomes part of EHR

https://www.nuance.com/healthcare/ambient-clinical-intelligence.html

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Other Considerations

- Malpractice insurance carrier to ensure your policy covers providing care via telemedicine
- Check with all insurance payors to know rules

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A Word about 21St Century Cares Act

- End of December 2020, MUST provide electronic access to all of EHI included in United States Core Data for Interoperability (USCDI)
- Elements in USCDI.
  - Patient demographics
  - Vital signs
  - Problem list
  - Medication list
  - Care team members
  - Plan of care
  - All of your clinical notes.
- Eliminate use of faxes & Start Using Your EHR's Communications Tools
- Contact your EHR vendor

USCDI: https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi
USCDI FAQ: https://www.healthit.gov/cures/sites/default/files/cures/2020-03/USCDI.pdf

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CODING AND BILLING

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Coding and Billing Review

- Telemedicine
- Virtual Check In
- E-visits
- Telephone Services
- Remote Physiological Monitoring
- What is next Post Pandemic – predictions and what we know.

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Types of Non-Face to Face Visit Codes

Non-Face to Face Services

- Virtual Check In
- E-visits
- Telephone Services
- Telehealth Services

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Medicare Virtual Check In Services

- Medicare pays "virtual check-ins" for patients to connect with doctor in lieu of office visit
- Established patients only
- Not related to medical visit in previous 7 days and does not lead to medical visit in next 24 hours
- Patient must verbally consent to services and verbal consent must be documented before service – At least annually
- Medicare coinsurance and deductible ($198) apply to these services

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Medicare Virtual Check In Services

- Can bill for these virtual check-in services furnished through several communication technology modalities

(Medicare G codes)

- **G2012** – Telephone
- **G2010** - Captured video or image

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Medicare Virtual Check In Services

G2012

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

Typical reimbursement is approximately $15

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Medicare Virtual Check In Services

G2010

- 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

- Typical reimbursement is approximately $12

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Virtual Check In Coding

Question:
Can codes G2010 and G2012 be billed on the same day, by the same practitioner, for the same patient?

Answer:
As long as all requirements for billing both codes are met, and time and effort are not being counted twice, HCPCS codes G2010 and G2012 may be billed by the same practitioner, for the same patient, on the same day.

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Medicare On-Line Digital Evaluations

- Medicare pays for patients to communicate with doctors without an office visit using **on-line patient portals**
- Must be patient-initiated
- Providers may educate beneficiaries on availability of services prior to patient initiation
- Pre-PHE was for established patients only
- Post-PHE not yet know if this will change or continue as now under 1135 Waiver for PHE

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Medicare On-Line Digital Evaluations

- Communication may occur over 7-day period
- Not related to medical visit in previous 7 days and does not lead to medical visit in next 24 hours
- Bill using 99421-99423
- Medicare coinsurance and deductible ($198) apply (Note providers can waive during PHP crisis only)

Normally required to store communication and ensure HIPAA compliance for ALL Patient Communications but <u>not</u> enforced during emergency

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Medicare On-Line Digital Evaluations

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
(National Average reimbursement = $15.52)

99422
Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11– 20 minutes
(National Average reimbursement = $31.04)

99423
Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
(National Average reimbursement = $50.16)

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Telephone Services

Currently COVERED by MEDICARE
Currently COVERED by NC MEDICAID
Some private carriers MAY allow
Check with each carrier to confirm on-going coverage

- Non-face-to-face evaluation and management (E&M) services provided using telephone **(no video available)**
- Used to report episodes of patient care initiated by **New or** established patient or guardian

-95 modifier ONLY applies to Telemedicine and not other non-face-to-care services

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Telephone Services

Do not report IF:

1. Call results in decision to see the patient within 24 hours or next available urgent visit appointment (considered part of preservice work for visit
2. Call refers to E/M service billed by provider within previous seven days whether requested by provider or not
3. Call is within postoperative period of completed procedure (part of post operative service
4. Reported 99441-99443 by same provider for same problem in previous seven days

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Telephone Services

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
(National average reimbursement = $14.44)

99442 ;11-20 minutes of medical discussion
(National average reimbursement = $28.15)

99443 ;21-30 minutes of medical discussion
(National average reimbursement = $41.14

(Do not report 99441-99443 when using 99339-99340, 99374-99380 for the same call[s])
(Do not report 99441-99443 for home and outpatient INR monitoring when reporting 93792, 93793)
(Do not report 99441-99443 during the same month with 99487-99489)
(Do not report 99441-99443 when performed during the service time of codes 99495 or 99496)

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Modifier -95

- **Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System**
- Synchronous telemedicine service is defined as a **real-time** interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional.
- Synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

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Medicare Telemedicine Service Billing

Deleted 2021

- 99201
- 99202
- 99203
- 99204
- 99205
- 99211
- 99212
- 99213
- 99214
- 99215

NOTE:
92002, 92012, 92004, 92014
ARE NOT INCLUDED

Under 1135 Waiver ONLY-
Must file Medicare with -95 modifier

Place of Service (POS) = 11 office

Under Waiver
POS = Where service typically provided

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Medicare Telemedicine Service Defined

CMS expectation:
Physicians use E&M code that best describes nature of care provided regardless of physical location or status of patient

If Provider NOT in typical location:

- **Still use Typical POS (11-office)**
- **Put actual location address in Block 32 for CMS 1500 form**

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Medicare Telemedicine Service Defined

CMS Exceptions 2020 (2021 Rules of MDM or Time):

1135 Waiver COVID-19 Public Health Emergency

Office E&M level selection for telemedicine services can be based on:

- **MDM**

or

- **Time, with time defined as all of time associated with the E&M on day of encounter**

and

- **Remove requirements for documentation of history and/or physical exam in record**

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Medicare Telemedicine Service Defined

- CMS expects providers will document E&M visits as necessary to ensure quality and continuity of care

For COVID-19 Changes in 2020

- **CMS maintaining current definition of MDM under 2020 rules (Changes Jan 2021)**
- **CMS maintaining typical times associated with office/outpatient E&M codes (Changes Jan 2021)**
- **CMS expects typical times under 2020 rules should be met for purposes of level selection (Changes Jan 2021)**

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Medicare Telemedicine Service Billing

Normally Telemedicine uses POS 02
Normally does not use modifiers
Normally pays at Facility rate
Normally patient has to be in specified place

Unknown what rules will be post PHE

BUT March 30,2020 CMS changed rules

Under 1135 Waiver:

1. **Add services available to be billed under Telemedicine**
2. **Use POS of 11- office (typical POS where service provided)**
3. **Use -95 Modifier to indicate Telemedicine Service**
4. **Will pay at Non-facility rate**
5. **Patient can be at most any remote location**

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Modifier Use Summary

-95 Modifier for telemedicine services ONLY

-CS Modifier only if services provided related to COVID-19 diagnosis

-CR Modifier is NOT required during this Public Health Emergency

-GQ Modifier if Alaska/ Hawaii using asynchronous telemedicine

-GO Modifier if telemedicine diagnosis is related to Acute Stroke diagnosis

Do not need modifiers for other Non-face-to-face services that not directly COVID-19 related

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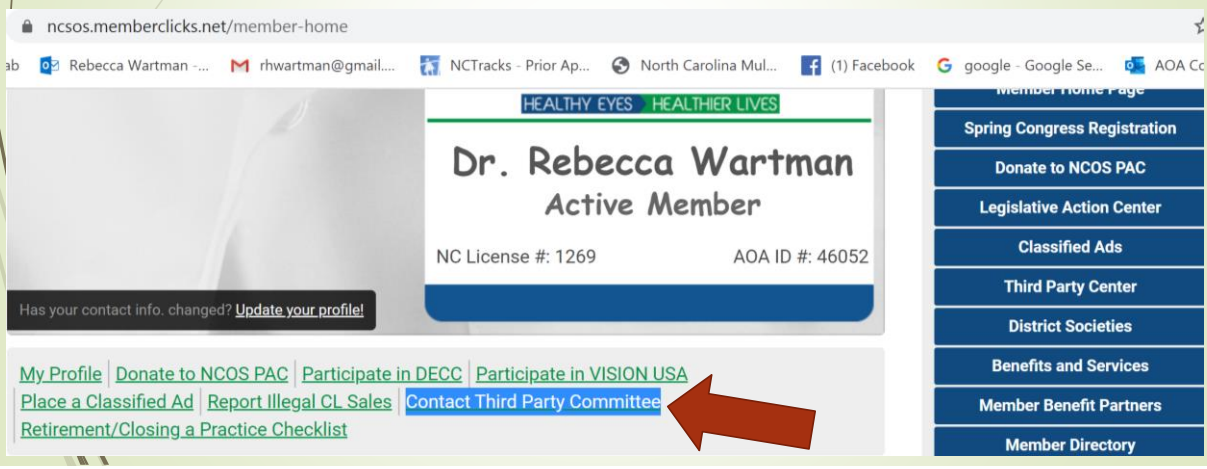
Click "Contact Third Party Committee" to submit any questions!
(on NCOS member login page)



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Resources

- **HIPAA Compliance**: https://www.healthit.gov/topic/privacy-security-and-hipaa/health-it-privacy-and-security-resources-providers
- **Getting Started Guidance**: https://www.aao.org/practice-management/article/teleophthalmology-how-to-get-started#testingvisualacuity
- **Printable eye charts:** https://www.aao.org/eye-health/tips-prevention/home-eye-test-children-adults
- **Printable Amsler Grid**: https://www.aao.org/Assets/6684654c-b054-454e-8e66-a1b2ec6d8234/637207568125830000/amsler-grid-pdf?inline=1
- **AOA Telehealth Guidelines**: https://www.aoa.org/AOA/Documents/Advocacy/position%20statements/AOA_Policy_Telehealth.pdf
- **NCBEO Telehealth Policies:** https://www.ncoptometry.org/board-policies/telemedicine-position-statement
- **NIH Article Ophthalmic Telehealth**: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7191296/
- **United States Core Data for Interoperability (USCDI):** https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi
- **USCDI FAQ:** https://www.healthit.gov/cures/sites/default/files/cures/2020-03/USCDI.pdf

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