PEARLS AND PRACTICES FOR VIRTUAL EYE CARE




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It is hard to believe that, a short few months ago, we were conducting business as usual. In early March, with the number of COVID-19–positive cases climbing precipitously in Colorado and an executive order by the governor to stop routine and elective patient care, we were suddenly facing a 90% drop in our clinic and surgical volume.

The changes to CMS telehealth policy announced on March 6 were potential game-changers, but they have also resulted in a race to understand and implement those changes. In our practice, harnessing virtual health capabilities has helped us to provide care to many of our patients. Telehealth will be a tool that can be carried on far beyond COVID-19.

KNOWLEDGE SHARE

We want to share some of the teleophthalmology pearls and practices that we have implemented and found to be helpful.

▸ **Pearl No. 1: Designate a team to lead your efforts.** If you run a solo practice, that team may be you or you and your practice manager. If you are in a multispecialty group or a large academic institution, as we are, it is best to task a small team to lead your virtual health efforts.

Your virtual health team should check daily for relevant changes to federal, state, institutional, and payer virtual health policies and regularly update the rest of your group. In our department, a group of four leads these efforts. Key updates are emailed and cached on a shared drive that was established to hold all documents and communications related to departmental COVID-19 information. Our team includes superusers, our medical director, and our practice administrator, and it oversees dedicated staff who serve as a resource to troubleshoot issues that arise.

▸ **Pearl No. 2: Know which telehealth visits can be used in ophthalmology and how.** E-visits may include video and telephone visits, image reviews, and online communication. Table 1 presents details about the types of visits allowed and their associated codes.

A first step is to identify which kinds of visits are appropriate for video and telephone virtual health. We tasked each division within the department to put together a list of patient diagnoses that would be appropriate for virtual health visits. The lists they generated included, for example, postoperative visits, external or adnexal evaluations, and complaints of red eyes.

You must also establish a virtual health workflow for urgent patient calls. Ours are now first triaged by a resident with attending oversight, then preferentially scheduled into a virtual health slot when appropriate.

Establish a protocol for staff members to verify that patients can participate in a virtual health visit. For example, for video visits, patients must have a private location they can be seen in during the appointment, and they must have access to a device that has a camera and microphone.

▸ **Pearl No. 3: Leverage virtual health to expand the patient population while minimizing face-to-face contact.** Ways to minimize contact include sending patients a vision testing chart and instructions ahead of their virtual visit via regular mail, secured email, or communication through your electronic health record. Great printable and mobile-friendly charts are available from the AAO and at the website farsight.care.

Similarly, for evaluations of lesions, periocular problems, or red eyes and for select postoperative evaluations (eyelid surgery, Mohs repair), you can ask patients to send a close-up photograph to you ahead of time using a secure patient communication service.

Another way to minimize face-to-face contact is to institute hybrid virtual health diagnostic visits. For certain time-sensitive visits, some elements of the examination must be performed in person, whereas the remainder of the visit can be conducted virtually. Therefore, we identified low-volume satellite locations where necessary diagnostic imaging or an IOP check could be performed. The patient would then return home, and a subsequent virtual health visit would be completed with the provider.

A modified version of the hybrid visit can be used in the clinic setting. For

example, all examination elements could be performed as per normal, but then the provider would step out of the examination room and complete counseling over a video system to limit the amount of time spent in close proximity to the patient.

We have also instituted drive-up IOP checks to maintain regular management of our glaucoma patients.

▶ **Pearl No. 4: Choose a video platform to use and one or two backups.** Our university-based hospital chose the VidyoConnect (Vidyo) video conferencing system, which we use in conjunction with our Epic electronic health record system. This service allows screen sharing so that we can show the patient test or imaging results, and it provides a whiteboard for freehand illustrations to supplement our ability to communicate with patients.

Be prepared to use a backup platform because one may work better than another for your patients. Other similar systems include Doximity (Doximity), Skype (Microsoft), FaceTime (Apple), Doxy.me (Doxy.me), and Zoom (Zoom Video Communications). Keep in mind that, for all of these, your device and your patient's device must have a camera, microphone, and speaker.

HIPAA compliance rules are currently relaxed, but that may change after the COVID-19 crisis abates. Refer to the US Department of Health and Human Services (HHS) COVID-19 website and note the most recent guidance from the HHS Office of Civil Rights regarding HIPAA and telehealth from March 20, which states:

"[Office of Civil Rights] is exercising its enforcement discretion to not impose penalties for HIPAA violations against healthcare providers in connection with their good faith provision of telehealth using communication technologies during the COVID-19 nationwide public health emergency."

▶ **Pearl No. 5: Get help.** If you have the luxury, it is worth having someone (medical assistant, technician, front desk staff member) on standby to help your visits go more smoothly by:

- Scheduling virtual health appointments;
- Calling the patient the day before his or her visit to prechart items such as history of present illness, reconciliation of medications, and allergy documentation; to obtain consent; and to ensure that all documentation is in place;
- Troubleshooting technology issues with the patient before and during calls;
- Rooming the patient, scribing for your visit, or providing medical interpretation; and
- Scheduling follow-up appointments.

We have also reintroduced trainee involvement in a virtual capacity to capture safe educational opportunities.

▶ **Pearl No. 6: Know your billing.** Table 2 outlines our estimated CMS reimbursement matrix.

TABLE 1. VIRTUAL HEALTH VISIT TYPES AND TIPS

Video Telehealth Visits
Coding tips: E/M 99211–99215, 99201–99205; Eye Codes 92002, 92012 • Reimbursement is equivalent to office visit; use E/M or Eye Codes (CMS 4/30/20) • For both new and established patients • Do everything you normally would for an office visit (HPI, ROS, medications, PMHx, SocHx, etc) • Bill on E/M or Eye data, or if more than 50% of the visit is spent on counseling/coordination, bill on time • For 99211 (CMS 4/30/20) must document: Physician order/specific directions for technician; technician SOAP note • Virtual supervision is allowed; not billable for same-day physician visit • Acceptable video platforms: VidyoConnect/Epic (Vidyo); FaceTime (Apple); Doxy.me (Doxy.me); Skype (Microsoft); others that are nonpublic facing
Telephone-Only Telehealth Visits
Coding tips: for Medicare and commercial payers: G2012 or 9944x; for Medicaid, use E/M codes • G2012: Brief check-in code for phone call lasting at least 5 minutes; flat fee • 9944x: coded by time • Medicaid: coded by time • For both new and established patients • Must be initiated by the patient • Don't bill these if you have seen the patient in the previous 7 days or plan to see the patient within the next 24 hours
E-Visits
Coding tips: online/secure patient communication only, 9942x • Bill by cumulative time over 7 days • Not billable if you have seen the patient in the previous 7 days • Must be initiated by the patient • For new and established patients
Review of Patient-Submitted Imaging
Coding tips: G2010 • Example: Patient uploads photograph to MHC; you review and give feedback to patient • May be combined with G2012 • Not billable if you have seen the patient in the previous 7 days or if your review leads to the soonest available appointment • For new and established patients
Abbreviations: E/M, evaluation and management; HPI, history of present illness; ROS, review of systems; PMHx, patient medical history; SocHx, social history; SOAP, subjective, objective, assessment, and plan; MHC, My Health Connection

▶ **Pearl No. 7: If your patient is out of state, verify that you can see him or her.** States have different rules around this, so make sure you check each time. Our hospital's virtual health command team took the lead on finding out what states allow us to conduct and bill for virtual visits. As of mid-April, nine states outside of Colorado allow Colorado-licensed providers to

TABLE 2. VIRTUAL VISIT REIMBURSEMENT MATRIX*		
Brief Check-In	**Facility-Based**	**Office-Based**
G2012 (5+ min)	$13.40	$14.89
Medicare Imaging	**Facility-Based**	**Office-Based**
G2010	$9.43	$12.41
Video Health Visit	**Facility-Based**	**Office-Based**
Established Patient Evaluation and Management		
99212 (10′)	$26.41	$46.92
99213 (15′)	$52.53	$77.14
99214 (25′)	$80.84	$111.78
99215 (40′)	$114.23	$150.02
New Patient Evaluation and Management		
99201 (10′)	$27.16	$47.29
99202 (20′)	$51.79	$78.26
99203 (30′)	$77.49	$110.67
99204 (45′)	$132.54	$168.70
99205 (60′)	$173.13	$213.02
Eye Codes		
92002 (new)	$48.82	$87.21
92012 (established)	$26.41	$46.92
E-Visit	**Facility-Based**	**Office-Based**
99421 (5′–10′)	$13.40	$15.64
99422 (11′–20′)	$27.51	$31.23
99423 (21′+)	$43.79	$50.50
Postop Visit (video, phone) 99204	**0**	**0**
Phone Codes	**Facility-Based**	**Office-Based**
99441 (5′–10′)	$26.41	$46.92
99442 (11′–20′)	$52.53	$77.14
99443 (21′+)	$80.84	$111.78
*Estimates based on Colorado CMS rates. Facility-based rates apply to most hospital-based care; office-based rates apply to most private practices. Please consult your coding specialist for the most accurate information.		

conduct virtual health visits, with varying levels of restrictions.

If you cannot legally see a patient who is out of state, you may still be able to perform a consultation with a provider located in that state (for example, an urgent-care provider seeing your patient) who can then administer care or treatment.

▸ **Pearl No. 8: Plan for post-COVID-19 life.** Evaluate what virtual health is doing for your practice. Are there protocols and workflows that you have been forced to change that are now more efficient? Look at your productivity metrics prelockdown versus during this pandemic. How much of your previous volume are you capturing? What is the expected revenue? Which parts of your practice might be amenable to keeping on some version of virtual health, should reimbursement for these types of visits be retained by payers?

At our institution, we collect data daily and analyze it weekly. Give your practice a hard look now to best plan for your future.

▸ **Pearl No. 9: Know your resources.** Beyond our internal hospital communications, we check these sites regularly for updates:

- AAO (www.aao.org/practice-management/telehealth);
- CMS (www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet);
- HHS (www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html); and
- HHS OCR (www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf). ■

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