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Telehealth – Part I **February 2019**

Telehealth is here, and it certainly isn't going to stop. This is a two-part series that will help break down how optometry can possibly use telehealth, how to document it, and how to get paid for the care. As with any new technology, it comes with fear of the unknown. The unknown regarding how it works, how it will integrate into current systems, and what the net outcome will be. When auto-refractors came out, eye doctors thought they would put us all out of business. Now you can't find an office without one! Once we learned what the technology could do and how it could help us and our patients, we brought it into our practices and use it every day. Telehealth is likely going to have the same result for us. I foresee doctors integrating telehealth into their brick and mortar practices. We all know that some things can be diagnosed with symptoms and a good photo, while others require an in-person physical exam. And for our patients, this integration of the two worlds could benefit everyone. This paradigm of integrated-telehealth gives our patients greater access to us and provides care the way they now expect to receive it. By implementing it into our practices, it will keep us in the loop of care. This does not have to be a tele-doc vs. real-doc battle.

What situations could yield themselves well to this technology? What if a long-standing patient with recurrent iridocyclitis and is known to be HLA-B27 positive develops a mild ache, circle-limbal injection, and photophobia on a Sunday afternoon? If the patient sends you a clear photo of the injection and a list of their symptoms, would you be comfortable calling in a steroid and scheduling them first thing Monday morning instead of rushing into the office on Sunday? If you know the patient, I think many of us would be okay doing it. If this were an unknown patient to us, certainly that changes the game. What if a parent sends in a picture of their 5-year-old with purulent discharge from both eyes? Again, that's probably within our comfort zone. But a non-descript red eye in a contact lens patient…I'm meeting them in the office! I think there is a role for this technology. And as develops, we will begin to understand its limits.

One of the factors that may slow our adoption of this technology is not knowing how to document and receive reimbursement for the services. Below we will explore how it is done. For self-pay patients, it is very simple: present the fee and they pay out of pocket. For commercial payers, you may actually code an office visit just as you would had seen the patient in the office. The appropriate level would be determined based on the level of history, physical exam, and medical decision making. Commercial payers may have certain requirements or restrictions. The only way to know would be to call them directly and ask if they cover telehealth services for their patients. Then ask what codes are eligible to be used or what modifiers need to be attached. They will likely require at least identifying the place of service as 02 – Telehealth.

Medicare has only allowed providers to bill for telehealth services if the provider is part of a Federally Qualified Health Clinic or Rural Health Center. These provide services to patients in remote areas where care to providers is quite limited. For the vast majority of us, this has excluded us from providing telehealth care to Medicare patients. Because they recognize that this restriction limits access to care to the majority of patients, Medicare accepted two new codes in 2019 for which all providers have the ability to use with any Medicare beneficiary who is an established patient. That means these patients must already have a relationship with the providing provider.

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*.

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.*

We will explore examples of these visits, and others, in Part II of this series. Times are changing, and we need to understand how.