The New Normal: Nuances of the Hybrid Telehealth/In-Person Exam

Telemedicine options can help you to stay in contact with your patients, and—by reducing the number of in-office visits—can help expand your patient exam capacity. But not everything can be done remotely, resulting in hybrid telehealth/in-person encounters.

The new normal. Owing to social distancing requirements and patient requests, histories taken by phone and drive-up intraocular pressure (IOP) checks are the new normal for many practices. Many ophthalmology practices have been offering telemedicine appointments for some conditions, and are combining these with in-person testing services.

Tips for the Hybrid Exam
When utilizing telemedicine hybrid encounters, keep the following issues in mind.

Protocol driven. Physicians should direct the scheduling of telemedicine hybrid encounters based on patient-specific criteria or a comprehensive clinical scheduling protocol.

Physicians must request tests ahead of time. All delegated testing services still require a physician order that is documented prior to performance of the test.

Document informed consent. Patients must verbally consent to the telemedicine encounter.

Frequency limits. A typical hybrid telemedicine encounter may include a combination of an onsite testing service with a subsequent telemedicine exam. For example, a common scenario may involve a dry age-related macular degeneration (AMD) patient visiting the office for a fundus photo and an optical coherence tomography (OCT) screening followed by a telemedicine examination. When coding for these hybrid exams, remember that payers may each have their own unique policy and frequency limit for each test performed.

Bundled codes. When you perform more than one test on the same day, review the Correct Coding Initiative (CCI) edits to see whether those tests are bundled together (e.g., fundus photo and OCT are still bundled).

What about MIPS? In the Merit-Based Incentive Payment System (MIPS), your score for some quality measures is based on your performance rate. When services are provided to a patient via telemedicine, that patient might be included when calculating the performance rate of some—but not all—quality measures.

Suppose, for example, you bill one of the E/M office visit codes (99201-99215) and you append modifier –95, which indicates that telemedicine was used. This patient encounter would be included in the performance rate if you are reporting measure 130: Documentation of Current Medications in the Medical Record but not if reporting measure 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

How do you know whether or not telehealth encounters are included when calculating a quality measure’s performance rate? First, go to aao.org/medicare/quality-reporting-measures and look for the quality measure that you are interested in. Next, check the list of CPT codes that show which patient encounters are included and see if there is a caveat about telemedicine modifiers at the end of that list.

Three Sample Scenarios
Consider the following hybrid scenarios.

Scenario #1: A 70-year-old woman schedules a follow-up evaluation of her dry AMD. Here’s what happens.

• A staff member obtains her history 

Ethics in Telemedicine
This April, the Academy published a new ethics Information Statement titled “Ethics in Telemedicine.”

In addition to touching on legal considerations, it covers six ethical issues: competence, informed consent, conflict of interest, confidentiality, continuity of care, and preservation of data.

To read the Information Statement, visit aao.org/ethics-detail/information-statement- ethics-in-telemedicine.

BY JOY WOODKE, COE, OCS, OCSR, ACADEMY CODING AND PRACTICE MANAGEMENT EXECUTIVE, AND SUE VICCHRILLI, COT, OCS, OCSR, ACADEMY DIRECTOR OF CODING & REIMBURSEMENT.
via a phone call and documents it in the medical record.
• Because the patient is at high risk for severe COVID-19 illness, a
telemedicine hybrid appointment is
offered based on the clinic’s scheduling protocol.
• The physician reviews the chart and assesses the previous exam, visual
acuity (VA), and findings.
• A retina OCT is ordered, and this
order is documented in the medical record.
• The patient is scheduled for a VA
test and OCT at the satellite office closest
to her home.
• A subsequent telemedicine appoint-
ment with the ophthalmologist is
scheduled at the next convenient date and
time.
• At the satellite office, a technician
tests VA and conducts an OCT clinic.
To enhance social distancing, this is
scheduled to start 30 minutes after the
previous patient. There is no wait for
the patient, and additional time is allotted for sanitation between tests.
• During the telemedicine appoint-
ment, the physician reviews the history, VA, and OCT, discusses the findings,
and provides recommendations to the
patient.

Scenario #2: A 62-year-old man is recalled for a four-month glaucoma
check. Here’s how a hybrid exam could take place.
• After reviewing the patient’s chart and previous visual fields and glaucoma
OCT, the physician considers telemed-
icine options due to the lack of availability for a timely clinic appointment.
• The patient is scheduled for an IOP
check at the next available drive-up clinic, with a follow-up telemedicine
appointment with the physician.
• The follow-up telemedicine encoun-
ter is conducted. The physician reviews the IOP, discusses current medications
and findings, and provides recommenda-
tions to the patient.

Scenario #3: How would you code this one?
• A patient comes into the office, and
a technician checks the patient’s VA and
IOP, and performs any other test(s) that
the physician has ordered (e.g., fundus
photography or OCT).
• The technician performs a slit-lamp exam via a video slit-lamp system.
• The physician is off site and views the slit-lamp exam remotely.
• While the technician is in the room with the patient, the tech gets the phy-
sician on video to finish the exam with
discussion and treatment.

Would this video discussion be
considered a telemedicine service (since the
physician is off site) or a regular
nontelemedicine service (since the
patient is in the office)? At time of press
the Centers for Medicare & Medicaid
Services (CMS) had not provided
direction for this type of scenario, but
it is the AAOE’s best judgment that the
video discussion portion of the visit
would be considered a telemedicine service.
Check this article at aao.org/eyenet for updates.

A Patient Won’t Come In?
During the current pandemic, patients are
sometimes reluctant to leave home and enter
physician offices, ambulatory surgery centers, and hospitals—even for visits and procedures that they need and want.

Data from multiple large health care
systems demonstrate that a personal
call from the physician is far more valuable and effective than a call from
staff in helping a patient return for
care. This appears to be particularly
true if the physician takes a few minutes to speak about the steps that are
being taken to keep patients and staff
safe—and to articulate the need for
continued care or surgery.

The bottom line: Nothing appears
to be more effective than the personal
relationship between patient and phy-
sician.

FURTHER READING. For more infor-
mation on telemedicine coding, visit
aao.org/practice-management/tele
health.