Telemedicine Protocols

Best Practices for Adopting Telemedicine in the Dry Eye Practice

EXPERTS

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*Increased tear production was seen at 6 months when used as directed.[1,2]

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INDICATIONS AND USAGE: RESTASIS® and *RESTASIS MultiDose*® ophthalmic emulsion are indicated to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca. Increased tear production was not seen in patients currently taking topical anti-inflammatory drugs or using punctal plugs.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS: RESTASIS® and *RESTASIS MultiDose*® are contraindicated in patients with known or suspected hypersensitivity to any of the ingredients in the formulation.

WARNINGS AND PRECAUTIONS

POTENTIAL FOR EYE INJURY AND CONTAMINATION: Be careful not to touch the container tip to your eye or other surfaces to avoid potential for eye injury and contamination.

USE WITH CONTACT LENSES: RESTASIS® and *RESTASIS MultiDose*® should not be administered while wearing contact lenses. If contact lenses are worn, they should be removed prior to the administration of the emulsion. Lenses may be reinserted 15 minutes following administration of RESTASIS® and *RESTASIS MultiDose*® ophthalmic emulsion.

ADVERSE REACTIONS: In clinical trials, the most common adverse reaction following the use of cyclosporine ophthalmic emulsion 0.05% was ocular burning (upon instillation)—17%. Other reactions reported in 1% to 5% of patients included conjunctival hyperemia, discharge, epiphora, eye pain, foreign body sensation, pruritus, stinging, and visual disturbance (most often blurring).

PLEASE SEE NEXT PAGE FOR A BRIEF SUMMARY OF THE FULL PRODUCT INFORMATION.

REFERENCES: 1. RESTASIS® (cyclosporine ophthalmic emulsion) 0.05% [prescribing information]. Irvine, CA: Allergan, Inc; 2017. **2.** *RESTASIS Multidose*® (cyclosporine ophthalmic emulsion) 0.05% [prescribing information]. Irvine, CA: Allergan, Inc; 2016. **3.** Symphony Health, PHAST Prescription Monthly, data through October 2019. **4.** IQVIA, Xponent PlanTrak, January 2019- October 2019. **5.** Managed Markets Insight & Technology, LLC. Yardley, PA: Managed Markets Insight & Technology, LLC; March 2020.

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RESTASIS® (Cyclosporine Ophthalmic Emulsion) 0.05% and RESTASIS MULTIDOSE® (Cyclosporine Ophthalmic Emulsion) 0.05%

BRIEF SUMMARY—PLEASE SEE THE RESTASIS® AND RESTASIS MULTIDOSE® PACKAGE INSERTS FOR FULL PRESCRIBING INFORMATION.

INDICATION AND USAGE

RESTASIS® and **RESTASIS MULTIDOSE®** ophthalmic emulsion are indicated to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca. Increased tear production was not seen in patients currently taking topical anti-inflammatory drugs or using punctal plugs.

CONTRAINDICATIONS

RESTASIS® and **RESTASIS MULTIDOSE®** are contraindicated in patients with known or suspected hypersensitivity to any of the ingredients in the formulation. *[see Adverse Reactions]*

WARNINGS AND PRECAUTIONS

Potential for Eye Injury and Contamination

Be careful not to touch the container tip to your eye or other surfaces to avoid potential for eye injury and contamination.

Use with Contact Lenses

RESTASIS® and **RESTASIS MULTIDOSE®** should not be administered while wearing contact lenses. Patients with decreased tear production typically should not wear contact lenses. If contact lenses are worn, they should be removed prior to the administration of the emulsion. Lenses may be reinserted 15 minutes following administration of **RESTASIS®** and **RESTASIS MULTIDOSE®** ophthalmic emulsion.

ADVERSE REACTIONS

The following serious adverse reactions are described elsewhere in the labeling: Potential for Eye Injury and Contamination
[see Warnings and Precautions]

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In clinical trials, the most common adverse reaction following the use of cyclosporine ophthalmic emulsion 0.05% was ocular burning (17%).

Other reactions reported in 1% to 5% of patients included conjunctival hyperemia, discharge, epiphora, eye pain, foreign body sensation, pruritus, stinging, and visual disturbance (most often blurring).

Post-marketing Experience

The following adverse reactions have been identified during post approval use of cyclosporine ophthalmic emulsion 0.05%. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Reported reactions have included: hypersensitivity (including eye swelling, urticaria, rare cases of severe angioedema, face swelling, tongue swelling, pharyngeal edema, and dyspnea); and superficial injury of the eye (from the container tip touching the eye during administration).

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary: Clinical administration of cyclosporine ophthalmic emulsion 0.05% is not detected systemically following topical ocular administration *[see Clinical Pharmacology (12.3)]*, and maternal use is not expected to result in fetal exposure to the drug. Oral administration of cyclosporine to pregnant rats or rabbits did not produce teratogenicity at clinically relevant doses *[see Data]*.

Data

Animal Data: At maternally toxic doses (30 mg/kg/day in rats and 100 mg/kg/day in rabbits), cyclosporine oral solution (USP) was teratogenic as indicated by increased pre- and postnatal mortality, reduced fetal weight and skeletal retardations. These doses (normalized to body surface area) are 5,000 and 32,000 times greater, respectively, than the daily recommended human dose of one drop (approximately 28 mcL) of cyclosporine ophthalmic emulsion 0.05% twice daily into each eye of a 60 kg person (0.001 mg/kg/day), assuming that the entire dose is absorbed. No evidence of embryofetal toxicity was observed in rats or rabbits receiving cyclosporine during organogenesis at oral doses up to 17 mg/kg/day or 30 mg/kg/day, respectively. These doses in rats and rabbits are approximately 3,000 and 10,000 times greater, respectively, than the daily recommended human dose.

An oral dose of 45 mg/kg/day cyclosporine administered to rats from Day 15 of pregnancy until Day 21 postpartum produced maternal toxicity and an increase in postnatal mortality in offspring. This dose is 7,000 times greater than the daily recommended human dose. No adverse effects in dams or offspring were observed at oral doses up to 15 mg/kg/day (2,000 times greater than the daily recommended human dose).

Lactation

Risk Summary

Cyclosporine is known to appear in human milk following systemic administration, but its presence in human milk following topical treatment has not been investigated. Although blood concentrations are undetectable following topical administration of cyclosporine ophthalmic emulsion 0.05% *[see Clinical Pharmacology (12.3)]*, caution should be exercised when **RESTASIS®** and **RESTASIS MULTIDOSE®** are administered to a nursing woman. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for **RESTASIS®** and **RESTASIS MULTIDOSE®** and any potential adverse effects on the breast-fed child from cyclosporine.

Pediatric Use

Safety and efficacy have not been established in pediatric patients below the age of 16.

Geriatric Use

No overall difference in safety or effectiveness has been observed between elderly and younger patients.

NONCLINICAL TOXICOLOGY

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis: Systemic carcinogenicity studies were carried out in male and female mice and rats. In the 78-week oral (diet) mouse study, at doses of 1, 4, and 16 mg/kg/day, evidence of a statistically significant trend was found for lymphocytic lymphomas in females, and the incidence of hepatocellular carcinomas in mid-dose males significantly exceeded the control value.

In the 24-month oral (diet) rat study, conducted at 0.5, 2, and 8 mg/kg/day, pancreatic islet cell adenomas significantly exceeded the control rate in the low-dose level. The hepatocellular carcinomas and pancreatic islet cell adenomas were not dose related. The low doses in mice and rats are approximately 80 times greater (normalized to body surface area) than the daily human dose of one drop (approximately 28 mcL) of cyclosporine ophthalmic emulsion, 0.05% twice daily into each eye of a 60 kg person (0.001 mg/kg/day), assuming that the entire dose is absorbed.

Mutagenesis: Cyclosporine has not been found to be mutagenic/genotoxic in the Ames Test, the V79-HGPRT Test, the micronucleus test in mice and Chinese hamsters, the chromosome-aberration tests in Chinese hamster bone-marrow, the mouse dominant lethal assay, and the DNA-repair test in sperm from treated mice. A study analyzing sister chromatid exchange (SCE) induction by cyclosporine using human lymphocytes *in vitro* gave indication of a positive effect (i.e., induction of SCE).

Impairment of Fertility: No impairment in fertility was demonstrated in studies in male and female rats receiving oral doses of cyclosporine up to 15 mg/kg/day (approximately 2,000 times the human daily dose of 0.001 mg/kg/day normalized to body surface area) for 9 weeks (male) and 2 weeks (female) prior to mating.

PATIENT COUNSELING INFORMATION

Handling the Container

Advise patients to not allow the tip of the container to touch the eye or any surface, as this may contaminate the emulsion. Advise patients to not touch the container to their eye to avoid the potential for injury to the eye.
[see Warnings and Precautions]

Use with Contact Lenses

RESTASIS® and **RESTASIS MULTIDOSE®** should not be administered while wearing contact lenses. Patients with decreased tear production typically should not wear contact lenses. Advise patients that if contact lenses are worn, they should be removed prior to the administration of the emulsion. Lenses may be reinserted 15 minutes following administration of **RESTASIS®** and **RESTASIS MULTIDOSE®** ophthalmic emulsion.
[see Warnings and Precautions]

Administration

Advise patients that the emulsion from one individual single-use vial is to be used immediately after opening for administration to one or both eyes, and the remaining contents should be discarded immediately after administration.

Advise patients to read the Instructions for Use for detailed first-time use instructions for the multidose bottle.

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Telemedicine from COVID to Today

By Paul M. Karpecki, OD, FAAO

If we had addressed telemedicine back in March 2020, when we were forced to temporarily shut down our offices due to COVID, this would have been the number one topic of the time, because how else were you going to see patients? All eye care providers had to do some level of telemedicine in order to practice. Fortunately, right around the same time, the US government loosened its regulations around, and expanded reimbursement for, telehealth visits. So many patients, who couldn't be seen any other way, wanted to do that. And telemedicine became much more accessible given that technology platforms we use every day—from EyecareLive, to the phone, Zoom, video conference calls, and more—were allowed to be used.

Here we are 10 months later still living in a COVID era, hitting our highest numbers since the outbreak of the pandemic, with shutdowns starting to happen again. So looking at telemedicine is relevant—not due to concerns that we're going to get shut down again, but rather because this is the future of practice. And if there are ways that we can create hybrid models to accommodate in-person and virtual patient visits, that's going to be ideal.

This is in no way implying that the in-person exam should be replaced with telehealth. That wouldn't be right or fair to the patient, and we couldn't do the proper level of medicine. But a telemedicine visit certainly can replace an initial or follow-up exam that normally would be conducted in person if the patient is hesitant to come in for any number of reasons.

Virtually, we can take advantage of a full range of medications and lid hygiene offerings to help get the patient's dry eye disease (DED) under control. The patient's treatment can involve Rx anti-inflammatory medications, as well as over-the-counter (OTC) products such as hydrating compresses, hypochlorous acid sprays, and lid hygiene products. So telemedicine can involve the entire gamut of strategies and therapies we have at our disposal.

Why Consider Telehealth

COVID left us all wondering what was going to happen to our practices and how we were going to navigate through this new environment. So when the government made telehealth exams more accessible with additional coverage, it opened up a whole other avenue of practice. And that's another reason why it's so important for the profession to be involved in medical eye care and practice full-scope optometry. If you're mainly seeing vision plan patients, none of that side of care ended up being covered by the new rules.

When eye care practices eventually reopened during the pandemic, social distancing precautions and personal protective equipment (PPE) became a critical element to keeping everyone in the office safe, and that hasn't changed. It's still being recommended that you spend no more than 8 minutes with a patient even while wearing PPE, and if you're within one foot of the patient, it should only be about a minute. In one study, 42% of healthcare workers reported COVID exposure after interactions within 6 feet of COVID-positive individuals for more than 10 minutes, although those wearing an N95 masks had lower seropositivity rates.[1] So that means we need to be doing quick slit-lamp and overall exams, and then move back outside of that one-foot zone. That obviously limits how many people can be in a reception or waiting area at once, and necessitates another route to increase the distance.

Relaxing of Rules

In March 2020, the CMS issued an 1135 waiver to offer Medicare beneficiaries broader access to services through telehealth. Prior to that, practitioners were very limited in how they could conduct telemedicine visits and what they could bill for it. With the relaxing of the rules, the changes kept the amount of reimbursement at the same level, but permitted a sliding scale based on established increments of time needed to conduct the exam or communicate

with the patient. The policy changes, designed to increase flexibility for the patient, remain in place to this day.

The latest update to the rules specifies that patients have to initiate telehealth exams. Doctors can educate patients that they offer telemedicine, and if patients choose that option, the exams will be reimbursed at the same level as in-person exams.

CMS Rates of Reimbursement for New CPT Codes

Importantly, a telemedicine visit has to follow the same procedures as a normal visit. On the EMR, the doctor has to report the time spent talking to the patient, the patient's HPI, any findings, which includes answers to the doctor's questions and results from questionnaires such as SPEED. Essentially, the exam has to be conducted in the same manner as an in-person exam to qualify for reimbursement.

The reimbursement rates for 99441 through 99443, which are the telehealth codes, increased from a high of $14 to a baseline of $46 through an upper level of $110.

The table in Figure 1 shows the CMS rates of reimbursement for the new CPT codes. For example, phone calls to new or established patients vary by installments of 5 to 10 minutes, 11 to 20 minutes, and over 21 minutes. A virtual check-in (CPT Code G2012), when a physician or other qualified health care professional who can report evaluation and management (E/M) services conducts a brief communication via a technology-based service, remains at a rate of $14. E-visits, online communications in which the doctor is following up and sending information to the patient, start at $15 for 5 to 10 minutes, and go up to $50. Doctor-to-doctor consultation is now billable as well. If I need to call and consult with a colleague to discuss care for a patient, that colleague can get reimbursed for the amount of time allowed under 99449, which is something we couldn't do in the past.

Logistics

As mentioned, these visits can be done by phone, video conferencing, Zoom, although specific telehealth software, such as EyecareLive, may allow for better imaging and logistics. The doctor must receive a verbal patient consent to begin the exam, which is documented in the EMR. After the exam is complete, the doctor relays to the patient the decided-upon therapies, adds that to the record, and confirms the patient demographics are in place. Looking ahead, the doctor may tell the patient something to the effect of, "We're going to bring you back for an in-office procedure down the road."

CMS Expansion of Telehealth With 1135 Waiver

According to the Centers for Medicare & Medicaid Services (CMS), as of March 6, 2020, and "for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances." These visits are considered the same as in-person visits and are paid at the same rate.

Prior to this waiver, Medicare initially could only pay for telehealth when the person receiving services was in a designated rural area, and left home to go to a clinic, hospital, or certain types of medical facilities to receive the services.

In 2019, the CMS made several changes to improve access to virtual care. Medicare started making payments for brief communications or "virtual check-ins," short, patient-initiated communications with a healthcare practitioner. And Medicare Part B separately paid clinicians for e-visits, non-face-to-face patient-initiated communications through an online patient portal.

Medicare beneficiaries can receive a specific set of services through telehealth including evaluation and management visits (common office visits), mental health counseling, and preventive health screenings. This is intended to help ensure Medicare beneficiaries, who are at a higher risk for COVID, are able to visit with their doctor from home as opposed to having to go to a doctor's office or hospital, which puts them and others at risk.

As part of the waiver, the CMS decided it would not take enforcement action against any health insurance issuer in the individual or group market that made mid-year changes to health insurance products to provide greater coverage for telehealth services, or reduce or eliminate cost-sharing requirements for telehealth services, even if the specific telehealth services covered by the change were not related to COVID.

Benefits of Telehealth

Safety is obviously the first major benefit to telehealth. One way I adapted my practice when it first reopened for in-patient visits is I would do the exam, and rather than have the patient wait around and be exposed to more people, I would create a quick video

Current Telehealth Reimbursement Codes (CMS) Place of Service (POS) 11

Type of Service	Description	CPT Code	Reimbursement
Video Visit	MD/OD/PA/NP uses real-time Audio + Video	99201-99205 (New Pt.) 99212-99215 (Established) + 95 modifier	$46-$211 $60-$148
Phone Calls	Phone call to new or established patient	99441 for 5-10 min 99442 for 11-20 min 99443 for >21min	$46 $76 $110
Virtual Check-In	5-10 min check in via phone/email/portal/text	G2012	$14
Photo Review	Review patient photo	G2010	$13
E-Visit	Online communication vis portal and/or email *cumulative x 7 days	99421 for 5-10 min 99422 for 11-20 min 99423 for >21 min	$15 $31 $50
Doctor-Doctor Consult (Consulting Doctor)	MD/OD/PCP consult with report sent	99446 for 5-10 min 99447 for 11-20 min 99448 for 21-30 min 99449 for >31 min	$20 $40 $61 $80
Doctor-Doctor Consult (Referring Doctor)	MD/OD/PCP requesting consult	99452	$40

Figure 1. CMS Rates of Reimbursement for the New CPT Codes

and send it by email to the patient, saying something like:

"Thank you for coming in today. I just want to remind you what we discussed. Here are the therapies I'm going to start you on. We're going to use a Bruder Moist Heat Eye Compress, I recommend you use this hypochlorous acid, and we've started a Restasis® prescription for three months, which was sent in."

This now-billable follow-up offered more peace of mind for the patient who knew it was important to have an in-person exam but who was feeling uncomfortable about being in the office.

Telehealth is a nice option for in-between visits to make sure patients are staying on their drops. If you tell patients you'll see them again in three months because you're avoiding having too many people in the office, they may give up on their medications or not be compliant with your treatment plan.

It's also an efficient way to get reimbursed for equivalent in-person visits and procedures, but you must track and document the time spent with the patient. Some time around August 2020, I remember making a series of patient phone calls after a no-show appointment and realizing afterward that I had made four calls in about 30 minutes, and couldn't have seen four patients in the office in that time. Sometimes the calls take longer, but overall you can increase your exam efficiency, collect more data, and call patients back with those results.

Building patient trust is another important benefit of telehealth. You might send an email or a video of what you dictated to the patient at the end of the visit to reinforce your prescriptions and instructions. Many patients don't take detailed notes during their time with you, so you can emphasize how you're keeping in mind their safety during this time.

In addition, the technology component can help the practice to appear leading-edge and stand out. Patients love that because they are able to recommend the practice to their family members and friends.

For practices considering telehealth, it is a much easier decision now due to greater patient awareness. Insurance companies and general medical practices are running ads, and more information is circulating in general discussing the benefits so it's easier to find people who want to use this option.

1. Sims MD, Maine GN, Childers KL, et al; BLAST COVID-19 Study Group. COVID-19 seropositivity and asymptomatic rates in healthcare workers are associated with job function and masking. Clin Infect Dis. 2020 Nov 5:ciaa1684.

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Contraindications: Do NOT use the iLUX® Device in patients with the following conditions: Patients whose pupils have been pharmaceutically dilated; patients who have undergone ocular surgery within prior 12 months; patients with ocular injury or trauma, chemical burns, or limbal stem cell deficiency (within prior 3 months); patients with active ocular herpes zoster or simplex of eye or eyelid or a history of these within prior 3 months; patients with cicatricial lid margin disease; patients with active ocular infection, active ocular inflammation or history of chronic, recurrent ocular inflammation within prior 3 months; patients with an ocular surface abnormality that may compromise corneal integrity; patients with lid surface abnormalities that affect lid function in either eye; patients with aphakia; or patients with permanent makeup or tattoos on their eyelids.

Warnings/Precautions: Federal law restricts this device to sale by or on the order of a licensed healthcare practitioner. The Disposable may not fit all eyes, such as eyes with small palpebral fornices. Use of the iLUX® device is NOT recommended in patients with the following conditions: moderate to severe allergic, vernal or giant papillary conjunctivitis; severe eyelid inflammation; systemic disease conditions that cause dry eye; in patients who are taking medications known to cause dryness; or patients with punctal plugs.

Potential Adverse Reactions: Potential adverse effects may include eyelid/eye pain requiring discontinuation of the treatment procedure, eyelid irritation or inflammation, temporary reddening of the skin, ocular surface irritation or inflammation (e.g., corneal abrasion, conjunctive edema or conjunctival injection (hyperemia)), and ocular symptoms (e.g., burning, stinging, tearing, itching, discharge, redness, foreign body sensation, visual disturbance, sensitivity to light).

Attention: Please refer to the User Manual for a complete list of contraindications, instructions for use, warnings and precautions for the iLUX® Device.

References:
1. Alcon data on file, 2019.
2. Alcon data on file, 2019.

Alcon

Elements of the Telemedicine Exam

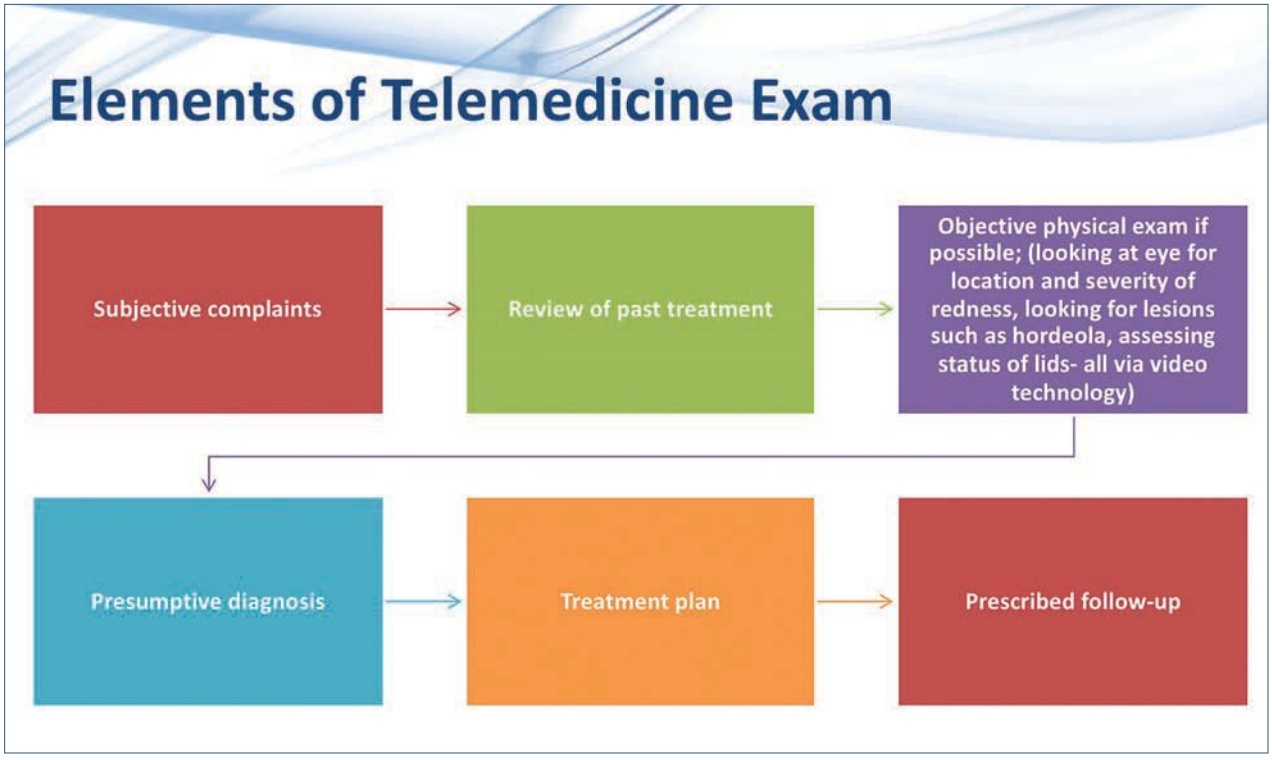
By Eric Schmidt, OD, FAAO

Exams conducted virtually should not differ significantly from in-person exams, but there are some important elements to remember to include in the telemedicine exam, as noted in the flowchart below.

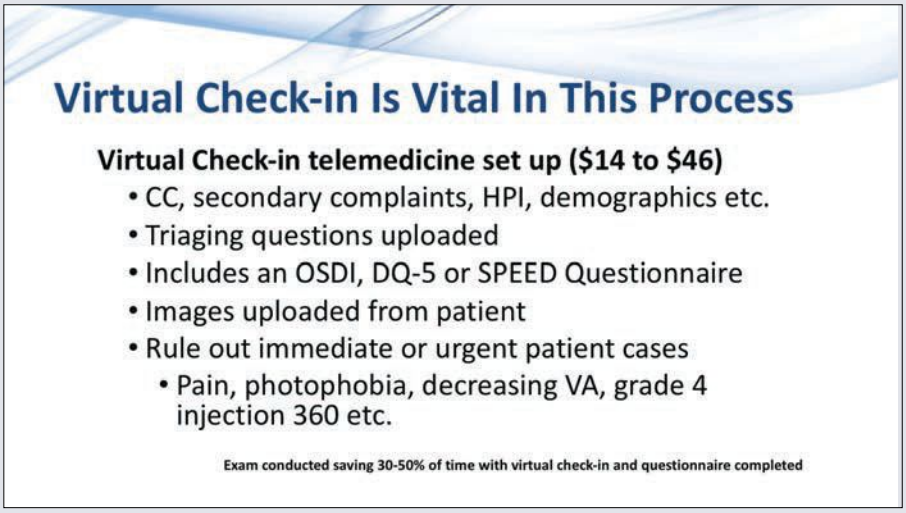
For one thing, you want to walk through patients' subjective complaints and a review of past treatments, and make detailed notes. For ocular surface disease, we certainly need to do this because all "dry eye" is not dry eye. Sometimes the symptoms could be the result of, for example, an allergic reaction, a hordeolum, or bacterial conjunctivitis. Using photo or video capabilities to examine the surface of the eye can reveal clogging of, or caps on, the meibomian glands. Any roaring papillae will become apparent if the patient pulls their eyelids down, and issues like subconjunctival hemorrhages will be fairly obvious. So it's possible to do a decent enough exam on telemedicine. From that information, the clinician makes a presumptive diagnosis, and then decides what treatment to use for the patient.

A follow-up visit becomes even more important when using telemedicine. Virtually, we don't have the advantage of tools such as a TearLab osmolarity test, a Zone-Quick Thread Tear test, or a slit lamp exam, so some kind of a check-in becomes an essential part of the process. Before that visit, the patient should complete the SPEED questionnaire or DEQ, or a technician can administer the OSDI. Tell the patient to return in a month for a follow-up visit, which could be virtual or in-person depending on the patient's condition.

Finally, these telemedicine encounters need to be recorded in the EMR in order to bill insurance companies.



Virtual Check-In



Dr. Schmidt: When virtual check-ins were first approved for reimbursement, the technician or front office staff would call the patient to get chief and secondary complaints. The staff member or doctor did the HPI, demographics, etc., and the triaging questions got uploaded to the patient's EMR, along with an OSDI or SPEED questionnaire, and any images the patients provided. The doctor, who used that information to rule out urgent cases, could get reimbursed $14 for that encounter. But that's changed a bit.

Dr. Johnston: Correct. Initially, the virtual check-in was non-video communication, i.e., a five-to-10 minute phone call to patients to gather information, HPI, symptoms, etc., with a CPT code of G2012, reimbursed at $14. Later, the 994 codes replaced the earlier code, and opened the door for higher reimbursement. For example, 99421 rose to $15 and increases with the length of time of the call.

Dr. Schmidt: So when a patient calls and asks for a virtual exam, the first step is to schedule an initial phone call, and plan to use code 99441 if the call ends up being five to 10 minutes, or 99442 if it goes 11 to 20 minutes, for example.

Dr. Johnston: Correct. Where we started utilizing this most was if, for example, a patient left a message with questions about drops they had been on since prior to COVID. In the past, we would call the patient back and never bill for that communication. But this gives us an opportunity to educate patients, make sure they're compliant with their medications, answer any questions, and talk about their treatment plan. And you can get reimbursed for that interchange.

Consensus Statement on Telemedicine Care for Dry Eye

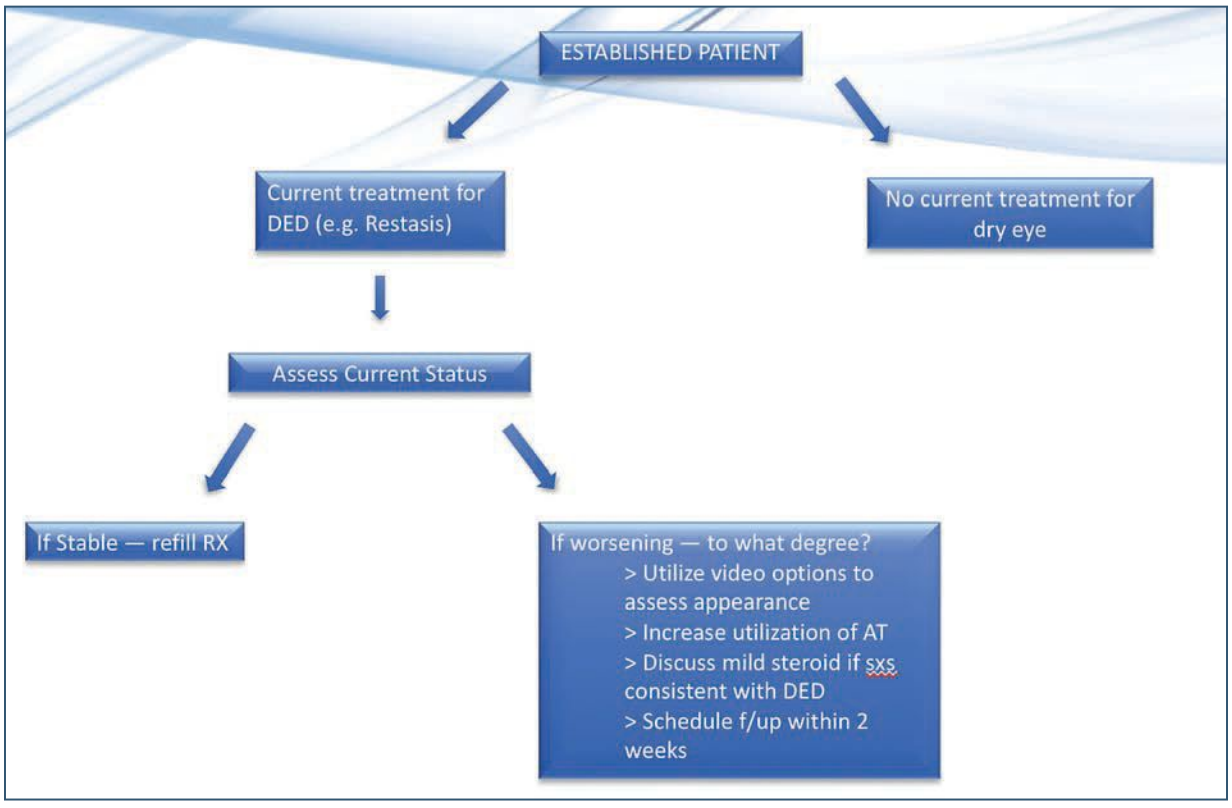
After the lockdowns began in March 2020, about 15 eye care doctors who focus on ocular surface disease got on a call to discuss the future of the dry eye practice and optometry in general. After generating a number of ideas, we decided to ask a series of questions to everyone in the group and compile a compendium of the answers. Glaucoma is one specialty that has issued expert consensus statements on various clinical topics for years. So we came up with a consensus statement on best practices for treating different kinds of dry eye disease patients via telemedicine. Here are some of the recommendations:

Established Patient

The first guidance is on an established patient who wants to initiate a telemedicine visit. This could be a patient who is already being treated for dry eye disease with, for instance, Restasis® or Xiidra®, not just artificial tears. The first thing the doctor does is assess the patient's current status. If the patient is doing well on their treatment, you can give them a 90-day refill and schedule a virtual or in-person follow-up visit in three months.

Conversely, when the established patient says they're getting worse, the question becomes, "How much worse are you getting—a little or a lot? Is it the worst it's ever been?" If possible, have the patient utilize a video option on their smartphone and hold the phone up to their eyes so you can check for redness and discharge, or any capping of the meibomian glands.

According to the consensus statement, one option for the worsening patient is to increase the utilization of artificial tears—from zero to two times a day, or two to four times a day, while continuing the



current Rx treatment the patient is on, e.g., Restasis or Xiidra. If the patient is visibly getting worse or they feel they're getting worse, then the discussion should revolve around the possibility of using mild topical corticosteroids. In my office, I would probably put the patient on a steroid short-term as a "rescue" for two to four weeks. The group had a lot of debate about this, but the consensus was that mild steroids are acceptable through a virtual visit if the symptoms are consistent with dry eye disease. However, the panel also said that if a steroid is prescribed virtually, the patient needs to be seen in person within two weeks.

Established Patient/No Current Treatment for DED

For an established patient not being treated for dry eye who schedules a telemedicine visit, during the exam you want to go through the subjective complaints and determine if the symptoms being described are consistent with dry eye. If both eyes are involved, the condition could be one that generally manifests bilaterally such as foreign body sensation, fluctuating vision, burning, irritation, things like that. If the symptoms are consistent with dry eye disease, the appearance on photos or video is in alignment, and you are confident it's a dry eye diagnosis, you enter that assessment into your EMR, and begin treatment.

According to the consensus statement, treatment should include artificial tears and possibly a prescription such as Restasis or Xiidra for chronic, anti-inflammatory relief. If the patient has been using artificial tears on their own, it's important to ask if the product is generic vs. branded, preserved vs. non-preserved, and the viscosity because that can be adjusted, too. Follow-up with the patient should occur in person in two to four weeks. Once the patient is under treatment, if they continue to get worse, you can ramp up therapy, but the doctors on the panel felt strongly that the patient should then be seen in person within a month.

New DED Patient Consult

For a first-time patient who calls in for a virtual dry eye disease consult, the recommendation is to first determine if symptoms are acute or longstand-

From the experts

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Answered by Dr. Paul Karpecki, OD, FAAO

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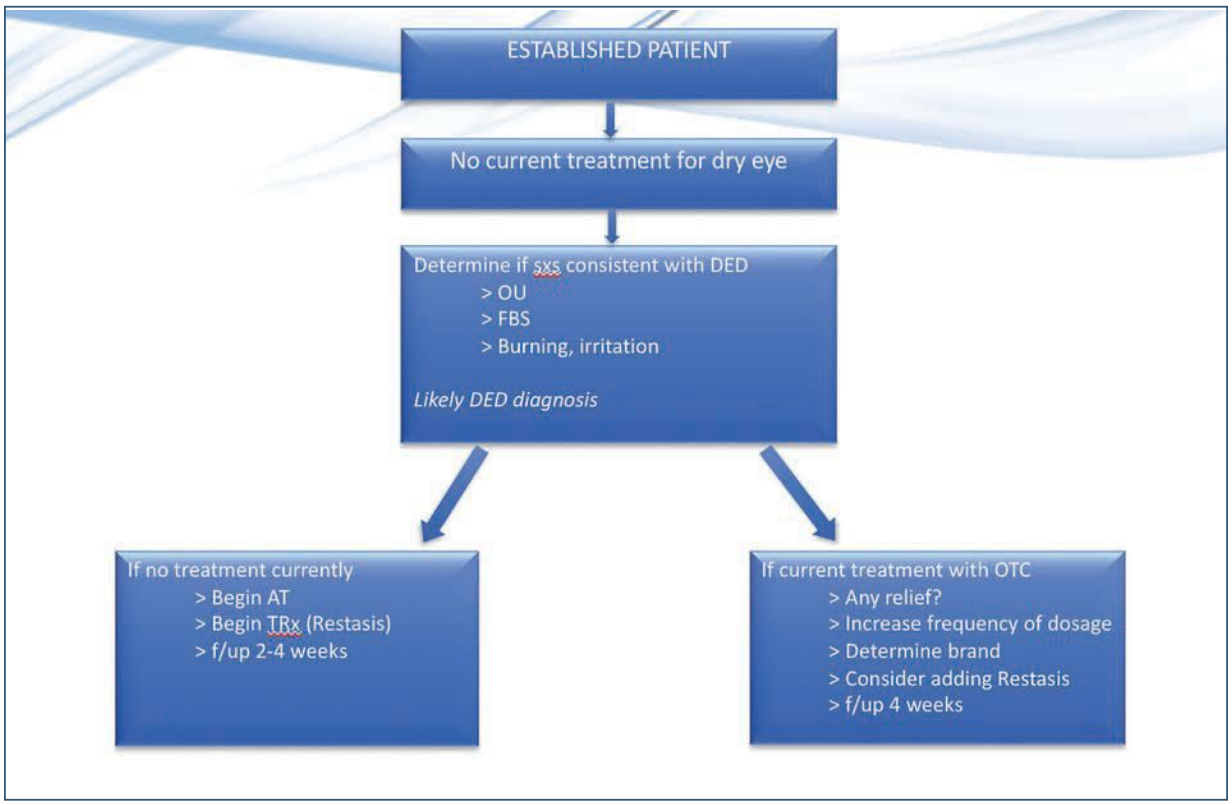
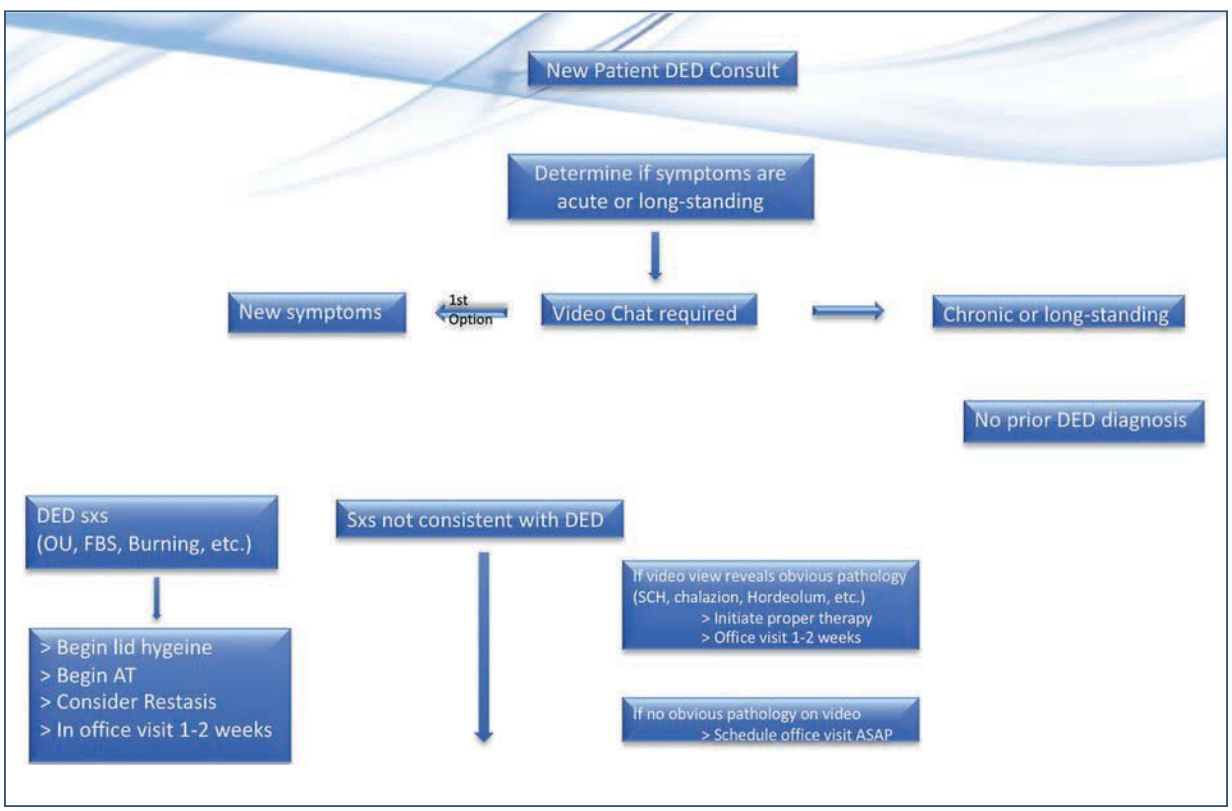
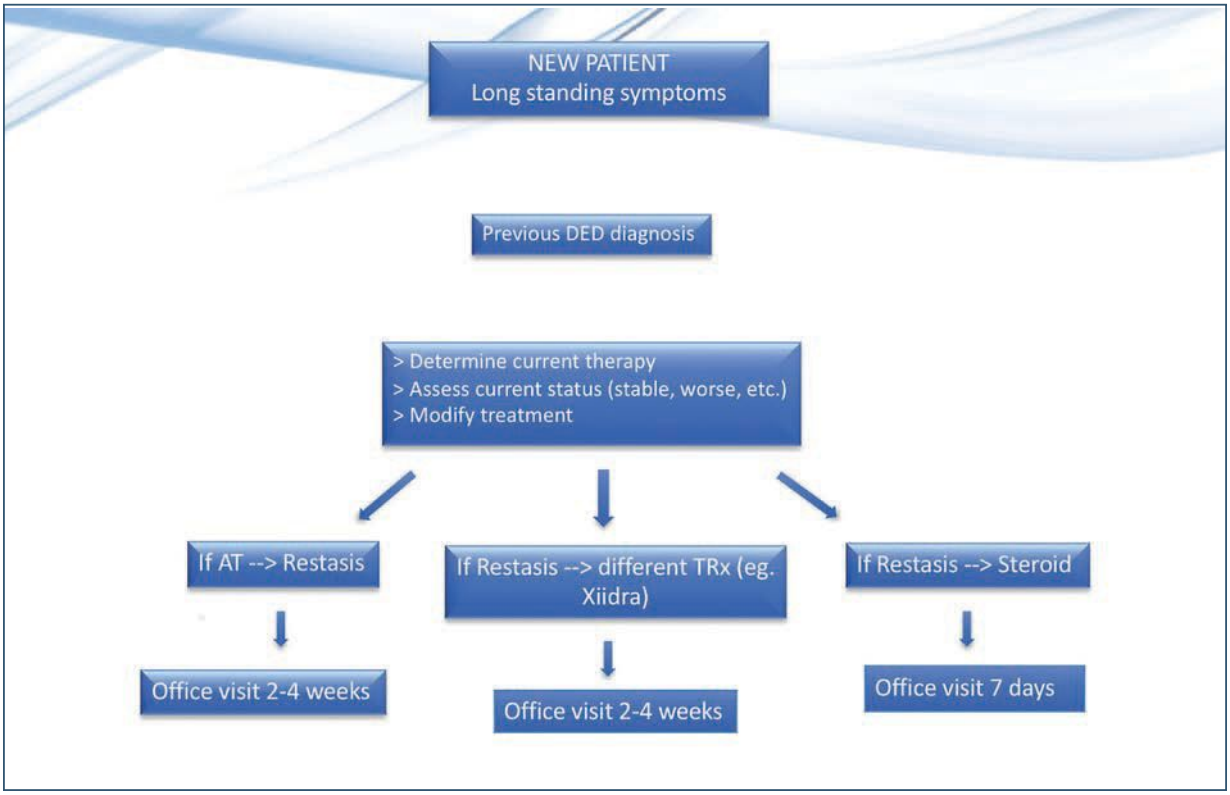
1. Tan J, Ho L, Wong K, et al. Cont Lens Anterior Eye. 2018;41(1):83-87.


ESTABLISHED PATIENT
No current treatment for dry eye
Determine if sxs consistent with DED
> OU
> FBS
> Burning, irritation
Likely DED diagnosis
If no treatment currently
> Begin AT
> Begin TRx (Restasis)
> f/up 2-4 weeks
If current treatment with OTC
> Any relief?
> Increase frequency of dosage
> Determine brand
> Consider adding Restasis
> f/up 4 weeks


New Patient DED Consult
Determine if symptoms are acute or long-standing
New symptoms
1st Option
Video Chat required
Chronic or long-standing
No prior DED diagnosis
DED sxs
(OU, FBS, Burning, etc.)
> Begin lid hygeine
> Begin AT
> Consider Restasis
> In office visit 1-2 weeks
Sxs not consistent with DED
If video view reveals obvious pathology
(SCH, chalazion, Hordeolum, etc.)
> Initiate proper therapy
> Office visit 1-2 weeks
If no obvious pathology on video
> Schedule office visit ASAP



ing, and whether they are getting worse. If they are worsening, a video chat is necessary to look at the patient's eyes and see what's going on. If the patient's symptoms are consistent with dry eye disease, the panel said to begin lid hygiene—whether it's lid scrubs, a Bruder Moist Heat Eye Compress, hot compresses, artificial tears, etc.—and to utilize the strategy at least four times a day. Also, the group felt it was important to recommend specific products to buy and not let the patient choose on their own. Beyond that, an anti-inflammatory drug such as Restasis or Xiidra can be initiated twice a day. And since the prescription is for a patient you've never seen before, the return visit should be in-office no less than two weeks later.

If the patient's symptoms during the initial video chat are not consistent with dry eye disease, the individual probably doesn't have dry eye disease and really needs to be seen in person. The individual could be dealing with an issue that is infectious in nature or may have no obvious pathology, which is even more significant. So don't assume a patient has dry eyes if the symptoms don't align with dry eye, as the symptoms really have to be there for us to make a definitive diagnosis.

New Patient, Longstanding Symptoms

One final scenario is a first-time patient with longstanding dry eye symptoms who opts to do telemedicine. In some cases, the patient may have been diagnosed by a doctor in a state where they no longer live. So the first step is to ask a series of questions about the dry eye: "Are you taking anything for it now? Were you taking something for it before? If so, why aren't you anymore?" Establish the patient's current status and treatment situation. Then modify treatment based on the presenting symptoms.

If the patient is using artificial tears only and is getting worse, the group's consensus was not to increase artificial tears, but to put the patient on some type of prescription drops such as Restasis or Xiidra, and then see the patient in person in two to four weeks. If the patient already is on a prescription drug and they're getting worse, the consensus was to switch therapy and see the patient in person in two to four weeks to look for any improvement. The third option was to prescribe steroids short-term as a rescue to help with symptoms, and then see the patient in-person starting in seven days.

Phasing In Telemedicine

By Josh Johnston, OD, FAAO

We're almost a year into this new COVID world, and some clinicians may not have incorporated telemedicine yet. So the call to action is for those who haven't done so to try and adopt it into their offices. I think we as optometrists are judged by the technology we use and the care we give to our patients, so we don't want to be left behind as a profession. We see so many other medical professionals adopting telehealth, and we don't want professionals such as nurse practitioners or other specialists seeing our patients simply because they offer more virtual options.

Offering Telemedicine

Eye care professionals who want to implement telemedicine should start by finding someone in the office who can champion the effort. Obviously, the technology component of telemedicine—whether it's a familiar app like Zoom, Google Duo, FaceTime, or something else—needs to be in place before the practice begins marketing the capability. Some secure platforms, such as EyecareLive, which existed prior to COVID, have gotten even better. So providers can decide what option works best for them and their patients. And there's nothing wrong with keeping things simple at the beginning to help everyone get acquainted with the new technology.

Once the staff is comfortable with the chosen platform, everyone in the office answering inbound patient calls should be trained to offer telemedicine as an option. During the shutdown, we had about 350 calls per day coming into our office, which is the normal volume between our six locations around Atlanta. At the time, we were only seeing about 30 patients urgently in the office, so we had to retrain our front desk to educate patients about our new virtual offerings.

Some cases that are a good fit for starting with telemedicine could include patients who call in with complaints of simple irritation, dry eye, or red eye, or it could be patients who live a distance away. One of the most acute walk-in cases we see is subconjunctival hemorrhage, which easily can be diagnosed over a telemedicine exam. Other possibilities include long-time patients who develop a mild viral or bacterial conjunctivitis, or elderly patients in nursing homes, who certainly can be seen for follow-up via telemedicine.

Once the telemedicine program is up and running, internal marketing—through social media, the website, the front staff answering calls, and doctor-patient communication—provides a variety of ways to educate patients that the office is offering telemedicine and how it works. As telemedicine visits steadily increase, so will the number of exams, enabling the practice to grow.

Coding and Billing

To be successful at telemedicine, doctors and staff members in the practice need to be aware of the current coding and allowable billing. Most of the utilization falls under the 994 codes for non-video, asynchronous communication. The traditional telemedicine exams with synchronous video typically use the 992 codes with the 95 modifier for video, or synchronous technology. Though these codes are for non-secure and non-HIPAA-compliant communication, they are still permitted at this time. In addition, most EMRs now incorporate these codes into their systems.

Increasing Telemedicine Volumes

During the shutdown, my office made a lot of proactive outbound calls. With six to eight weeks of appointments on the books, staff members reached out to patients to try to address their issues and see how they were doing. At the same time, they discussed our new telehealth options, which many patients elected to give a try. So there are different ways to get this going.

We're doing about two telemedicine calls a day now, so we'll see where the numbers move over time. But telehealth is the future of where medicine is heading. In all cases, dry eye fits really well into the telemedicine paradigm. We can listen to patients' complaints about their symptoms, safely diagnose them, and prescribe therapies that ultimately decrease inflammation and help patients produce more natural tears. Obviously, we want to see patients in the office at some point, but telemedicine is a great addition to the practice for a variety of reasons, so I challenge all eye care providers to try it if they haven't done so yet. ✭

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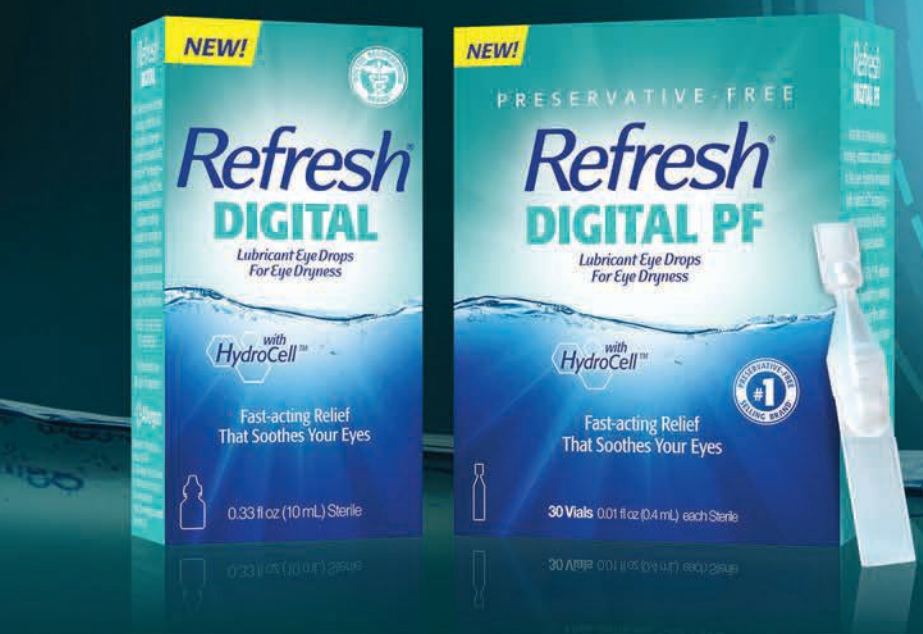

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