National Association of Optometrists and Opticians
Professionalism Consumerism Education

TO: California Board of Optometry
FROM: Joe Neville, Executive Director,
National Association of Optometrists and Opticians
Joseph B. Neville
RE: Regulation of Ocular Telemedicine
DATE: August 3, 2020

Thank you for the opportunity to comment as the California Board of Optometry considers the regulation of ocular telemedicine and the impact of such regulation on the health, safety and overall well-being of the California public. While the continued discussion of the use of telemedicine by optometrists in California is not on the agenda for the Board meeting currently scheduled for August 13 and 14, 2020, we thought it appropriate to provide the Board with further information and a set of principles that we believe should be followed by the Board in its review.

The National Association of Optometrists and Opticians is consumer-service oriented, dedicated to the proposition the consumer's visual care needs are met most completely and economically by the free market, in the tradition of the American business system. NAOO members collectively represent over 9000 co-located eye care offices and optical dispensaries, including over 800 locations in California, serving millions of patients and eyewear customers each year.

We have reviewed the Board's previous discussion of the issues involved with the use of telemedicine and submitted comments previously on May 14 of this year. Unfortunately, there was little discussion of the issues we raised by the Board during the May 14 meeting and no opportunity for public comment at that time. We have re-submitted those comments related to telemedicine in the attached end note. [i]

We now want to elaborate on these comments. We encourage the Board to consider the following principles for regulating in the public interest. The Board should not add to the current regulation of the use of telemedicine by optometrists unless:

1. There is credible evidence that the currently unregulated practice can clearly harm or endanger the public health, safety or welfare and the potential for harm is easily recognizable and not remote or dependent on tenuous agreement;
2. The public needs and can reasonably be expected to see a net benefit from the regulation (after considering the added costs or other burdens of the proposed regulation, including reducing access to care and making the patient experience less attractive); and

3. The public cannot be effectively protected by other means in a more cost-beneficial manner.

When considering the impact of any proposed new regulation, the Board should focus on the overall impact of the proposal on the eye health **and visual acuity** (not eye health alone) of the people of California, looking at four elements:

A. Access to eye care,
B. Cost of eye care
C. Quality of eye care and
D. Patient experience and satisfaction with the care they receive.

With these principle and measures in mind, the NAOO offers the following guidelines for the Board's consideration.

USE OF TELEMEDICINE FOR EYE CARE COMPARED TO OTHER HEALTH CARE

Ocular telemedicine should not be viewed differently than other branches of telemedicine. Telemedicine has been used in eye care for years. See the American Telemedicine Association "Practice Guidelines for Ocular Telehealth-Diabetic Retinopathy", Third Edition, 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7187969/

Use of telemedicine also has a long history in radiology, and in recent years, particularly following the outbreak of the COVID-19 pandemic, utilization of telemedicine has expanded rapidly in primary care, dermatology, mental health, dentistry and many other fields.

STANDARD OF CARE

The standard of care for telemedicine should be the same as that for in-person care. Meeting the standard of care is patient-specific; not every patient will need the same tests and diagnostic procedures. However, the optometric profession is largely in agreement as to the appropriate battery of tests and procedures to evaluate the eye health and visual acuity/need for correction of refractive error for healthy patients. These initial tests and procedures are discussed in detail later in this comment and can be performed by telemedicine.

Telemedicine can also facilitate the referral and scheduling of further in-person testing when the optometrist determines such additional or follow-up care is clinically appropriate. The standard of care for eye care within the scope of practice should be the same for optometrists as that for ophthalmologists.

PRESCRIBING CORRECTIVE EYEWEAR

(A) Using telemedicine to prescribe Class I and Class II medical devices should be allowed unless there is solid evidence of health and safety problems with the use of the prescribed devices. Prescribing corrective eyewear should not be treated the same as prescribing opioids, abortifacients, narcotics and dangerous drugs.

(B) Initially prescribing, renewing or refilling a prescription for corrective eyewear should be subject to the same standard of care as exists with in-person care. The NAOO has seen no evidence justification for a distinction between the methods used for an initial Rx and a renewal of an Rx unless the same distinction exists in-office and is justified by a clinical reason.

ESTABLISHING THE PATIENT-PROVIDER RELATIONSHIP

Patients and doctors should be able to establish patient-doctor relationships by an examination (i) in person, (ii) through face-to-face interactive, two-way, real-time communication, or (iii) store-and-forward technologies, as determined by the practitioner. The practitioner should have the freedom to use her professional judgment regarding the use of information from clinically relevant photographic, video or similar electronic images or the patient's relevant medical record.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

Informed Consent - multiple forms of consent should be allowed; the simplest, least intrusive method that is likely to be effective is preferred. Informed consent need only include a confirmation of the patient's and practitioner's name and relevant identification information, including location and follow-up contact information. There should be no requirements to make warnings or disclosures about the use of telemedicine versus in-person care unless the existence of material differences are substantiated by clinical or other reliable evidence.

RECORD-KEEPING REQUIREMENTS

Telemedicine care and in-person care should meet the same record-keeping requirements, including duration, privacy, security and patient access.

FOLLOW-UP CARE

The decision to refer or recommend follow-up care should be left to the doctor's professional judgment. If the initial doctor thinks a follow-up visit (either in-person or remotely, with the original practitioner or a referral provider) is necessary, the doctor should proceed accordingly. After a patient-provider encounter, whether remote or in-person, the patient should be able to access the doctor upon request for a reasonable period following the initial care and the doctor should be reasonably available to discuss questions and any concerns of the patient.

DELEGATION; TRAINING AND SUPERVISION OF ASSISTANTS

Use of support personnel to assist a patient in-office with a remote optometrist should be allowed with general supervision, where the optometrist is responsible to ensure that the assistant is properly trained and is following the standing orders or protocols that the provider has established for the delegated functions. The optometrist should not delegate decisions requiring professional judgment.

MINIMUM EYE EXAMINATION REQUIREMENTS; REFRACTION

(A) Technology exists that allows a comprehensive eye exam to be conducted for a patient at an originating site by an optometrist or ophthalmologist at a distant site. The Board should allow the optometrist to determine what equipment, instrumentation and

technology to use to examine, diagnose and treat patients, as long as such use meets the standard of care.

(B) The American Optometric Association (AOA) describes an eye exam on its website and makes clear that the optometrist has discretion in her or his professional judgment.[ii] All of the following tests and data collection can be done with ocular telemedicine.

a. Chief Complaint - assessment of the patient's reason for getting an eye exam
b. General Physical Health History - complete health history to screen for physical conditions and medications that may affect eyesight
c. General Ocular Health History - complete eye health history including family history of eye conditions, disease, or medication
d. External and Internal Eye Health Evaluation - examination for the signs of eye disorders, including cataracts and other eye disorders
e. Current Prescription Analysis - evaluation of current lens prescription, if applicable
f. Visual Acuity - test for the eyes' ability to see sharply and clearly at all distances
g. Refraction - test for the eyes' ability to focus light rays properly on the retina at distances and close by
h. Tonometry - test to measure internal fluid pressure of the eye (increased pressure may be an early sign of glaucoma)
i. Visual Coordination - check for external eye muscle balance and coordination
j. Accommodative Ability - test of the eyes' ability to change focus from distance to near
k. An exam may also include tests for color vision and depth perception, visual fields, and other vision skills, as needed.

(C) The National Association of Vision Care Plans (NAVCP) has recently adopted a policy where members have agreed that the typical vision benefit for a complete eye exam and refraction that includes specific elements may be provided remotely by providers who can perform the exam with telemedicine.[iii] The NAVCP membership includes such well-known vision plans as Aetna, Avesis, EyeMed, MESVision, Spectera (United Health), Versant (Davis, Superior) and VSP. Together these companies provide vision care coverage to millions of Californians. The Board should ensure that such eye care telemedicine benefits are available to the California public.

(D) Not all patients need (benefit from) a comprehensive eye examination at every visit with an optometrist or ophthalmologist. Nor must every element of the comprehensive eye exam be performed every time a doctor conducts a comprehensive eye exam. All the elements of a comprehensive eye exam need not occur on the same day.

(E) While we support the inclusion of a refraction as part of a complete optometric exam, the refraction is not technically an element of a comprehensive eye exam as defined by the AMA Code of Professional Terminology. See the CPT code definition of a comprehensive eye exam. Medicare covers a comprehensive eye exam when medically indicated but does not cover refractions.

(F) The Board should not restrict an optometrist's professional judgment to issue or update a prescription for corrective eyewear using telemedicine by either mandating in-person exams or by requiring a comprehensive eye exam be conducted for every patient every

time corrective eyewear is prescribed. Optometrists should have the professional discretion to determine what tests are necessary to prescribe corrective eyewear. The standard of care for prescribing corrective eyewear does not require every element of an eye exam to be performed on the patient.

We appreciate the opportunity to share these comments with the Board and would be happy to discuss these and other relevant matters relating to the use of ocular telemedicine with the Board or any of its members upon request. We look forward to learning what the Board determines regarding the issues presented.

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[i] From the May 14, 2020 letter to the California Board of Optometry on behalf of the National Association of Optometrists and Opticians from Joe Neville, Executive Director.

We agree that refraction (and relatedly, prescribing corrective eyewear) should be seen as a separate issue versus performing a comprehensive eye exam. In fact, a comprehensive eye exam by definition in the CPT codes does not include a refraction. The two can be performed independently, and ODs should be allowed to use independent professional judgment as to what elements of a comprehensive eye exam should be performed, if any, when a person's eyewear prescription is updated.

The Board should evaluate the frequency of the need for correction of visual acuity as well as the frequency and demographic distribution of eye health risks and problems.

There is little if any evidence that patients can't understand the need for a comprehensive eye exam or recognize that as a separate issue from how they benefit from improved visual acuity by using corrective eyewear. If a patient needs education, it's incumbent on the professionals with the support of the Board to educate, rather than to deny refractive services in order to force a patient to get a comprehensive eye exam.

Similarly, there is no evidence to support a requirement that a patient-provider relationship must begin with an in-person encounter. There are multiple methods to ensure patient understanding and consent to beginning a patient-provider relationship remotely.

There is plenty of evidence that most if not all elements of a comprehensive eye exam can be performed by a remote interactive (synchronous) exam by a licensed OD or physician. Additionally, it is almost always simple and easy to schedule an in-person visit should the examining practitioner determine that additional information is needed that can't be gathered in a telemedicine encounter. A patient's health is not protected, much less improved, by denying access to some forms of testing or examination by telemedicine that meets the standard of care.

It would be helpful for the Board to be more forthcoming about the nature of the "low but rising" number of complaints related to telemedicine. Is the basis of the complaint related to the patient's health and safety or economic? Is the source of the complaint a competitor or a consumer? Exactly how many have occurred over what period of time?

The Board would benefit from a more comprehensive review of the policies and consumer health and safety issues related to ocular telemedicine (both with optometry and with medical boards and professional associations) in other states, and with federal sources including the VA & the Indian Health Services.

Finally, the COVID-19 pandemic has led many states to loosen old restrictions on telemedicine. It will be useful to evaluate what has happened as a result. As many have pointed out in the numerous writings on this topic, the use of telemedicine going forward will be of great use to optometrists and benefit to patients. We recommend that the Board have an open mind about its use and allow the licensed optometrist to use their professional judgment (as

medical boards typically allow physicians to do) in deciding what forms of telemedicine to use and on what patients.

[ii] https://www.aoa.org/patients-and-public/caring-for-your-vision/comprehensive-eye-and-vision-examination

[iii] See the NAVCP Policy at https://secureservercdn.net/198.71.233.184/5df.048.myftpupload.com/wp-content/uploads/2020/07/NAVCP_PPP_Telemedicine-Policy-Statement_FL_6-29-2020.pdf

The NAVCP Ocular Telemedicine Policy describes a telemedicine eye exam as follows:

A comprehensive telemedicine eye examination includes at least the following procedures when professionally indicated, and Providers must use equipment and data collection techniques consistent with or exceeding the accepted standards of care for in-person eye care services.

i. *Detailed case history*
ii. *Lensometry*
iii. *Autorefraction*
iv. *Keratometry*
v. *Tonometry*
vi. *Visual field screening*
vii. *Anterior segment/external ocular video imaging*
viii. *Wide field retinal imaging*
ix. *Subjective refraction*
x. *Near refraction*
xi. *Binocular testing*
xii. *Ocular motility assessment*
xiii. *Neurological/emotional status*
xiv. *Pupillary function assessment*

- *Additional testing typically available with an in-person eye examination, including but not limited to color vision, stereopsis, tear function/stability, etc. be available from the Provider, and performed and documented in the medical record whenever indicated.*
- *A Dilated Fundus Evaluation (DFE) performed in-person by a Provider who is an Optometrist or Ophthalmologist be available whenever professionally indicated or when requested by the patient at or within a reasonable distance from the Originating Site within seven days.*