Ambulatory Telehealth

Ambulatory telehealth combines many of the considerations that are shared throughout other telehealth use-cases. Ambulatory telehealth visits can be delivered to patients in a variety of different ways. Direct to Patient visits have become much more common during COVID, and we have provided specific information on that use-case in a different module. This section will focus on workflow considerations for scheduled visits when connecting with a patient at another healthcare facility. These types of visits were common prior to COVID, because Medicare would only reimburse for visits when a patient was located at a qualified healthcare facility during the visit. CMS has waived this location requirement during the Public Health Emergency, which has dramatically increased access to telehealth.

Types of use cases and work flows that are included in ambulatory telehealth:

- Direct to Patient
    - Scheduled
    - On-Demand
- Connecting with a patient at another healthcare facility
    - Scheduled
    - On-Demand (this use case is possible, but rarely employed due to staff resources and workflow considerations)

Workflow Considerations

Scheduling. It can be challenging when coordinating schedules between two facilities, and the patient. If you are a distant site, and are conducting outreach to a small Rural Health Clinic, the originating site (where the patient will be located) may have significant limitations on when telehealth visits can be scheduled- especially if they are sharing the space with other outreach activities, or dedicating already-limited staff for these visits. It is a good idea to work through the resources needed for telehealth visits (staffing, clinic space, and technology), and to document the arrangement between the two facilities.

Clinical Appropriateness. Not all ambulatory visits can or should take place via telehealth. Provider discretion and comfort with telehealth is strongly recommended when scheduling telehealth visits. If additional diagnostic assistance is needed at the originating site, it is important to ensure that the staff is comfortable and competent in what is being asked of them.

Originating Site Staffing. A nurse or medical assistant can be useful to the workflow to help patients on the originating site end and providers on the distant site end navigate a visit. At the very least, a staff member in the room with the patient can ensure that the patient and provider get connected on the telehealth platform. This person may be referred to as a 'telepresenter.' During visits when a patient requires more diagnostic assistance, a telepresenter can also assist with procedural or diagnostic aspects of the visit, as needed and communicated by the provider. The need and availability of a telepresenter should be identified and communicated between the sites prior to the appointment, and should also be communicated to the patient.

Hardware and Software Requirements. The minimum that is necessary for an ambulatory visit between facilities is a device (computer or tablet) with a camera and microphone. Some sort of mounted device is recommended so that the patient or tele-presenter does not need to hold the device for the duration of the visit. A poor camera angle, or unsteady image can result in a poor-quality visit for the provider- and may negatively impact their visit.

Vitals can be taken by a nurse or MA, and verbally given to the provider at the distant site if the originating site and distant site do not share an electronic health record. The types of conditions that a telehealth provider is treating will help determine what type or types of digital peripheral devices may be needed to conduct the visit- a digital otoscope may allow a provider to get a look in a patient's mouth, and a digital stethoscope may be helpful for a cardiologist.

Provider Credentialing

One of the significant considerations for ambulatory telehealth when connecting with another healthcare facility is ensuring that providers are credentialed appropriately. If a specialist from a health system plans on doing telehealth outreach to a critical access hospital, they will need to be credentialed at that facility. Full credentialing can be a lengthy and resource-heavy process. CMS and The Joint Commission have put out guidance on moving through this process in a less-burdensome way, which includes expedited credentialing, and credentialing by proxy. More information on this topic can be found at CCHP.

Geographic Restrictions and Provider Licensure

Health care providers must be licensed in the state where the patient is located during a telehealth appointment. When connecting with another healthcare facility, provider licensure is not a concern as long as both facilities are located in the same state. Some states have

temporarily relaxed licensing rules during the current public health emergency. The Federation of State Medical Boards is tracking adjustments by states; the full current list can be obtained here. Some state licensing boards include Montana as part of their interstate licensure compact. Montana is part of the Interstate Medical Licensure Compact. Interstate licensing compacts exist for other clinical provider types as well.

Billing

The distant site can bill for appropriate CPT codes for telehealth visits. In addition to The Center for Connected Health Policy's helpful Billing Guide, The American Academy of Family Physicians has put together a guide of coding scenarios for telehealth visits during the COVID-19 pandemic. While there are many eligible telehealth codes, standard outpatient office visit codes are commonly used. Providers may select the level of service based on time or Medical Decision Making (MDM).

If connecting to an eligible originating site, that site will be able to bill for the originating site fee (Q3014), and potentially any additional procedural charges that may be applicable to the visits.

The Center for Connected Health Policy has also created a Fact Sheet for telehealth coverage policies during COVID-19, which can help with determining what organizations can bill for during the public health emergency.

For the duration of the Public Health Emergency (PHE), Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are able to bill for distant site services. Prior to the PHE, telehealth was only available to FQHCs as originating sites. The Center for Connected Health Policy has a Fact Sheet for FQHCs and RHCs for when they are leveraging telehealth as a distant site. For additional resources for FQHCs and RHCs, HRSA has a page of FAQs as it relates to COVID and health centers, and the Rural Health Information Hub has also compiled resources for FQHCs, many of which touch on telehealth and COVID.

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