TELEPSYCHIATRY & TELEHEALTH: Current Applications and Future Implications

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Overview of Presentation

• Terms & Definitions
• A Brief History of Telehealth
• Practice Guidelines
• Important Aspects in the Practice of Telepsychiatry & Telehealth
• Current Areas of Application
• The Future of Telepsychiatry & Telehealth
Definitions

• **Telehealth**: the transmission of health related services or information over telecommunication infrastructure including both clinical (telemedicine) and non-clinical elements (educational services and administrative support) of health care.

• **Telemedicine**: the provision of clinical services from a distance; the use of electronic information and communication technologies to provide and support healthcare when distance separates the participants.

• **Telepsychiatry**: mental health services provided by a psychiatrist or psychiatric practitioner from a remote location over secure, two-way, interactive, audiovisual equipment.

• **Originating Site (Spoke Site)**: point where the patient and/or patient’s physician is located.

• **Distant Site (Hub Site)**: point where the Telehealth specialist or provider is located.
Telehealth Delivery

- **Synchronous**: real-time video conferencing patient consultation and diagnostic treatment.

- **Asynchronous**: store and forward technologies involving electronically transmitted pre-recorded videos and digital images between primary care providers and medical specialists.

- **Remote Patient Monitoring**: electronic devices transmit patient health information from the home or facility to health care providers in a separate location.
A Brief History of Telemedicine

First Generation
- The first telemedicine system was created in Nebraska in 1959 by the University of Nebraska: two way closed-circuit TV using microwave technology.
- The Nebraska Psychiatric Institute in Omaha and the state mental hospital, 112 miles away, transmitted demonstrations with patients for medical students.
- Telecopiers were used to transmit and receive printed information.

Second Generation
- Unlike first generation; which was not interoperable.
- Integration with legacy systems and peripheral devices.
- Led to multi-application systems.

Third Generation
- Advent of interactive video-conferencing systems.
- Multiple interface and applications.
- Real-time live interactions as well as digitally stored processes.
- Public & private sector applications and collaborative ventures.
- Stable cost efficient broadcast infrastructure.
Practice Guidelines

• The American Telemedicine Association (ATA) released the Practice Guidelines for Video-Based Online Mental Health Services in May 2013.

• Companion document to the ATA Practice Guidelines for Videoconferencing-based Telemental Health released in 2009 that focused on real-time videoconferencing-based telemental health services using technologies other than the internet.
Clinical Guidelines for Internet-Based Telemental Health

• Provider and Patient Identity Verification

• Provider and Patient Location Documentation

• Contact Information Verification

• Verification of Policies for Contact Between Sessions:
  o Licensing laws
  o Emergency Protocols
  o Mandatory Reporting Requirements
  o Provider Payment/Reimbursements
Clinical Guidelines for Internet-Based Telemental Health

• Patient Appropriateness for Telepsychiatry

• Limited data and studies

• Safety issues

• Cognitive capacity

• Support system

• Complicated medical conditions

• Competence around technology
Informed Consent

- Consent should be conducted with the patient in real-time
- Local, regional, and national laws regarding verbal or written consent should be followed
- Provider should document the provision of consent in the medical record
- Consent should include all information contained in the consent process for in-person care as well as information specific to the nature of telepsychiatry
- Topics should include: confidentiality and its limits in specific electronic communication, agreed upon emergency plan, documentation and storage of patient information, potential for technical failure and back-up plan, protocol for contact between sessions, conditions for termination and/or referral to live provider
Clinical Guidelines for Internet-Based Telemental Health

Emergency Management & Patient Safety

• Competence in the practice of Telepsychiatry

• Completion of basic education and training in suicide prevention

• Knowledge of jurisdictional laws for involuntary hospitalization and duty to warn requirements

• Establish basic procedures for emergency situations:
  o Identify local emergency resources and phone numbers
  o Location of nearest hospital emergency department capable of managing psychiatric patients
  o Patient emergency contact/family information.
  o Knowledge of emergency response time
  o Contact for local professional and emergency personnel

• Collaboration with local pharmacy and primary care physician
Clinical Guidelines for Internet-Based Telemental Health

Technical Guidelines
• Key features: videoconferencing application, device characteristics, privacy and security measures.
• Hardware, software, cloud application-based options.
• Must meet all confidentiality and security requirements issued in HIPAA and HITECH regulations.
• Connectivity: bandwidth of 384 Kbps or higher in each of the downlink and uplink directions providing a minimum of 640 x 360 resolution at 30 frames per second.
• Wired connection preferred method over wireless for greater reliability.
• Point-to-point encryption that meets recognized standards: FIPS 140-2 Federal Information Processing Standard is the US Government security standard.
Growth of Telepsychiatry

• National shortage of psychiatrists
• Increased demand for care
• Rising costs and declining reimbursements
• Increase in wait times and decrease in visit times
• Stigma of mental health treatment
• Rural and underserved populations
• Corrections and military applications
Benefits of Telehealth

Patients
• Better outcomes from more timely access to specialists
• Higher quality of care
• Reduced travel time
• Reduced cost of care
• Increased collaboration of care
• Reduced hospital admissions or readmissions

Physicians
• Extend clinical reach to patients who can benefit from their expertise
• Improved utilization of services, productivity and reimbursement
• Reduced travel time
• Improved quality of life
• Increased collaboration and integration of care
Barriers and Challenges

- Cost to establish program
- Reimbursement issues
- Licensure
- Infrastructure
- Regulatory and institutional barriers
- Technophobia
Correctional Centers


Authors: E. Fuller Torrey MD, Sheriff Aaron D. Kennard MPA, Sheriff Don Eslinger, Richard Lamb MD, James Pavle.

• Three times more seriously mentally ill persons in jails and prisons than hospitals.
• At least sixteen percent of inmates in jails and prisons have a serious mental illness.
• Forty percent of individuals with serious mental illnesses have been in jail or prison at some time in their life.
Government and Military Applications

- Department of Veterans Affairs operates the largest Telehealth program.
- Large scale study from 2006-2010 with almost 100,000 VA mental health patients showed that after initiation of Telehealth services hospitalization utilization decreased by twenty-five percent.
- The Army’s Telemedicine and Advanced Technology Research Center (ATRC) and Advanced Technology Program (ATP) drive collaborative partnerships and award grants to private partners.
Rural and Underserved Areas

• Sy Atezaz Saeed, MD Professor and Chair of Psychiatry at Brody School of Medicine at East Carolina University.


• Statewide Telepsychiatry program in North Carolina began operations in January 2014.

• State invested $4 million over two years and project will be overseen by the DHHS Office of Rural Health and Community Care.

• Fifty-eight counties in NC qualify as federally qualified Health Professional Shortage Areas due to lack of mental health providers.

• Majority of NC emergency departments do not have access to a full-time psychiatrist.
Market Analysis of Growth

- InMedica news report: Telehealth projected to reach 1.8 million patients worldwide by 2017.
- U.S. telemedicine spending will grow to $2.2 billion in 2018 from $240 million in 2013: annual growth rate of 56%.
- New lobbying group created to promote federal and state policy changes to spur growth: the Alliance for Connected Care.
- Four Drivers of Telehealth Demand (InMedica)
  1. Federal-driven demand
  2. Provider-driven demand
  3. Payer-driven demand
  4. Patient-driven demand
Government and Policy

- 2011 Service members’ Telemedicine and E-Health Portability Act (STEP)
- Credentialed health care professionals could provide care across state lines to military personnel and veterans without having to obtain a new medical license in each state where a patient resides
- Resulted in a drastic reduction in hospitalizations for those patients supported by the program
- Savings of $2,000 per patient, per year
- 2014 National Defense Authorization Act
- Authorizes funding and sets policy for the U.S. Department of Defense included amendment to expand health care coverage through telemedicine for service members transitioning to civilian life
- Extends previous coverage by an additional 180 days for all services rendered through telemedicine
Government and Policy - continued

HR 3077: TELE-MED Act of 2013

• Allows certain Medicare providers licensed in one state to provide Telehealth services to Medicare beneficiaries in another state
• Builds on the STEP Act regulations to expand services to Medicare recipients
• HR 3750: The Telehealth Modernization Act of 2013
• Establish Federal standards for Telehealth
• Create a nationwide Telehealth definition to provide clarity regarding the scope of healthcare services that can be safely delivered via Telehealth
• To encourage health care providers to utilize innovative technologies to provide greater and more efficient patient care
FSMB Interstate Medical Licensure Compact 2014

• Creation of an Interstate Medical Licensure Compact Commission
• Autonomous body consisting of members of each state medical board
• Provides a streamlined process that allows physicians to become licensed in multiple states
• The Compact creates another pathway for licensure and does not otherwise change a state’s existing Medical Practice Act
• Affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter requiring the physician to be under the jurisdiction of the state medical board where patient is located
• Coordinated Information System with a database of all physicians licensed
• Joint investigation power and full oversight
Future Directions

• The adoption of a national standard in definition of services, security, interactivity, regulations and policy
• Interoperability of all information systems and infrastructure
• Complete technological integration of services and facilities
• Public-private assimilation
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Telemedicine - Behavioral Health Services
Webinar Hosted by Magellan of Virginia
May 22, 2015

Jeff Nelson, Policy Analyst Senior
Virginia Department of Medical Assistance Services
Definition and DMAS Coverage

- Telemedicine is real-time, or near real-time, transfer of medical data and information using interactive audio/video connections for diagnosis and treatment.

- Telephone calls, e-mail, fax transmissions and similar electronic measures are not included and should not be billed to DMAS.

- DMAS specifies the services where telemedicine may be utilized. DMAS does not recognize telemedicine for all covered services.

www.dmas.virginia.gov
DMAS Interests in Telemedicine Coverage

- Improved member access to medical services.
- Improved compliance in following provider suggestions for care and self-management of medical condition.
- Medical services rendered at an earlier stage of disease, improving long term outcomes.
- Reduction in services such as hospitalizations, emergency department usage and transportation.
DMAS Interests in Telemedicine Coverage

- Allows for an opportunity to work proactively with physicians and other providers, in DMAS evaluating their suggestions for expanding telemedicine coverage and adopting the suggestions where feasible.

- DMAS telemedicine coverage has expanded over the years based in part on additional services suggested by providers.
Covered Services

- Services that may be delivered via telemedicine include:
  - evaluation and management;
  - behavioral health;
  - specialty medical procedures such as echocardiography and obstetric ultrasound;
  - speech therapy (school-based); and
  - radiology procedures.
The telemedicine “originating site” is the office or other location of a provider enrolled with DMAS or its contractors where the Medicaid member is located.

DMAS has identified the types of providers whose office or other location may serve as an originating site.

The provider or a designee must be with the member at the originating site during the telemedicine encounter, with limited exceptions such as the member reporting injuries due to physical abuse.
Originating Sites

• The originating site has audio/video equipment and an electronic connection with the office or other setting of a “remote provider”.

• The originating site service is billed using procedure code Q3014 and procedure modifier GT.
Remote Site

• The remote provider is enrolled with DMAS or its contractors and renders services via telemedicine to the member at the originating site.

• Remote provider has audio/video equipment and a electronic connection with the originating site.

• Billing and reimbursement of services by the remote provider follow the same DMAS processes as when the services are delivered conventionally. A telemedicine procedure modifier is to be entered on the billing form.
Telemedicine Equipment

- Equipment must be of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face encounter.

- Staff must be proficient in the operation and use of the telemedicine equipment.

- Costs for telemedicine equipment and communication lines are not reimbursed by DMAS or its contractors.
Telemedicine encounters must be conducted in a confidential manner, and any information sharing must be consistent with applicable federal and state laws and regulations and DMAS policy.

Health Information Portability and Accountability Act of 1996 (HIPAA) confidentiality requirements are applicable to telemedicine encounters.
DMAS issued a Medicaid Memo, “Updates to Telemedicine Coverage,” on May 13, 2014. It has a complete description of telemedicine coverage.

The memo is available on the DMAS website at:
https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId={AB3083CE-C7AF-4CDD-9AA3-BFFBDEC445A9}&impersonate=true&objectType=document&id={D63341CB-653B-47CC-ABAC-96EBF0A08C07}&objectStoreName=VAPRODOS1.
Service Delivery Models

- Comprehensive coverage, such as Fee-for-Service, or limited coverage such as Plan First

- Managed Care Organization; Anthem, CoventryCares, INTotal Health, Kaiser Permanente, Optima Family Health and Virginia Premier
Managed Care Organizations (MCOs) provide access to health care benefits, preventive care and care coordination for the majority of Medicaid/FAMIS members.

MCOs cover “traditional” Behavioral Health (BH) services including inpatient and outpatient (individual, family, and group) therapies and medication management.

“Non-traditional” BH services are carved out of MCO contracts, and are provided to MCO members through Magellan and paid through fee-for-service.

DMAS contracts with MCOs include the use of telemedicine. MCOs must cover telemedicine at least to the extent it is included under fee-for-service coverage.
• BH providers using telemedicine for services provided to MCO-enrolled members must follow their respective contracts with the MCOs.

• The MCO may utilize different service authorization, billing, and reimbursement guidelines than those used for members receiving services paid through the Medicaid fee-for-service coverage.
Magellan administers a coordinated care model for BH services for Medicaid and FAMIS members with fee-for-service coverage, including members who participate in Medicaid home and community based waiver programs.

Magellan performs administrative functions such as provider enrollment, service authorization and claims payment on DMAS’ behalf, as well as supporting a call center for members and providers.
• Magellan administers traditional BH services for members with fee-for-service coverage.

• Magellan administers non-traditional services, (such as community mental health rehabilitation and substance abuse treatment services) for both the fee-for-service and MCO models.

• Magellan authorizes non-traditional BH services for MCO members and all BH services for FFS members, including services provided through telemedicine.
In-state Provider Enrollment

- In-state providers are providers operating within the borders of Virginia and within 50 miles outside of the Virginia border.

- In-state BH providers must be enrolled with Magellan. Provider enrollment information can be found at: http://www.magellanofvirginia.com/for-providers-va/join-the-network.aspx.

- In-state providers interested in billing both BH and medical services must enroll with both Magellan and DMAS.
In-state Provider Enrollment

- Online DMAS provider enrollment, as well as downloadable provider enrollment forms, are accessed at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal
Service and Billing Requirements

• Providers of telemedicine services are expected to fully comply with service documentation and other coverage and billing requirements described in the Virginia Medicaid provider manuals.

• The use of telemedicine must be noted in the service documentation of the patient record including the date, length of time of the session, and signature of the remote provider (or originating site provider).
Service and Billing Requirements

- The procedure modifier GT (for interactive telemedicine) is to be entered on the billing form when Behavioral Health services are rendered. The modifier is to be used by both remote providers and originating site providers.
Allowed Remote Provider Types, Sites and Miscellaneous Requirements

a. Psychiatrist, clinical psychologist, clinical social worker, professional counselor, psychiatric, clinical nurse specialist, psychiatric nurse practitioner, licensed marriage and family therapist/counselor, licensed school psychologist, and substance abuse treatment practitioner;
b. Physicians;
c. Nurse practitioners and clinical nurse specialists;
d. Nurse midwives.
e. Providers must have the appropriate required license from the Department of Behavioral Health and Developmental Services (http://www.dbhds.virginia.gov) and be enrolled with Magellan.
f. Providers above plus:

- Rural Health Clinics
- Federally Qualified Health Centers
- Hospitals (includes general, state mental, private mental, long stay, rehabilitation)
- Nursing Facilities (skilled nursing, medical & intellectual disability, intermediate care).
f. Provider types above plus:

- Health Department Clinics
- Renal Units (dialysis centers);
- Community Services Boards (mental health-intellectual disability provider)
- Residential Treatment Centers-C
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# Billing for Behavioral Health Services

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<td>99201-99215</td>
<td>Evaluation and management-office visits or other outpatient visits (can be a BHSA service)</td>
<td>b., c., d.</td>
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<tr>
<td>99221-99223, 99231-99233</td>
<td>Initial and subsequent hospital care (can be a BHSA service)</td>
<td>b.</td>
</tr>
<tr>
<td>H0036</td>
<td>Crisis Intervention</td>
<td>e.</td>
</tr>
<tr>
<td>H0050 with HM, HN, HO, or HQ modifier</td>
<td>Substance abuse crisis intervention</td>
<td>e.</td>
</tr>
<tr>
<td>Q3014</td>
<td>Telemedicine facility fee</td>
<td>f.</td>
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Out-of-State Physician Enrollment

• DMAS telemedicine coverage allows only out-of-state physicians to participate. They are considered remote providers.

• Out-of-state providers have a service address on their DMAS enrollment application which is beyond 50 miles of the Virginia border but within the continental United States.
Out-of-State Physician Enrollment


• Out-of-state physicians interested in billing both BH and medical services must enroll with both Magellan and DMAS. The “Telemedicine” specialty must be indicated. DMAS enrollment is performed by at https://www.virгинiamedicaid.dmas.virginia.gov/wps/portal.
An out-of-state physician enrolling with Magellan or DMAS must provide the following information:

- Virginia Department of Health Professions medical licensure information;
- Non-Virginia state medical licensure information; and
- Attest on the enrollment form by marking “Yes” in response to the question “Are you a participating Medicaid provider?”.
Out-of-State Physician Reimbursement

- Out-of-state physicians are reimbursed the professional component amount for the billed procedure, if the amount is specified on the DMAS reimbursement file.

- If the professional component is not on the file, the physicians are reimbursed the global amount on the file for the service.
### Billing for Behavioral Health Services by Out-of-State Physicians

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Commonwealth Coordinated Care (CCC) is a voluntary initiative that coordinates care for individuals who:
- Are eligible for full Medicare (entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D);
- Are eligible for full Medicaid;
- Are age 21 or older; and,
- Live in certain regions of Virginia.

CCC began in March 2014 and was phased-in on a regional basis.
Commonwealth Coordinated Care and Telemedicine

• CCC is designed to be the single entity accountable for coordinating delivery of primary, preventive, acute, behavioral, and long-term services and supports.

• Individuals in CCC are enrolled in one Medicaid-Medicare Plan (MMP) that provides most Medicare and Medicaid-covered services.

• A Medicare-Medicaid Plan (MMP) is an organization that is:
  – Responsible for care coordination; and
  – Is a payer and provider of covered benefits.

• Current MMPs include Anthem Healthkeepers, Humana and Virginia Premier.
Commonwealth Coordinated Care and Telemedicine

- Under CCC, telemedicine includes current DMAS telemedicine coverage and may also be offered for the following services:
  - Remote patient monitoring, such as for persons with congestive heart failure, diabetes, or pulmonary disease; and
  - Services provided in home-based settings, such as for hospice care or home dialysis. Persons must meet criteria for homebound as described in regulations.

- Further information can be found at: http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx
The GAP Program began January 12, 2015 offering a limited, yet targeted, package of benefits for uninsured individuals who have a serious mental illness.

Eligibility criteria include:
- Individuals ages 21-64;
- U.S. citizen or lawfully residing immigrant;
- No health insurance including Medicaid, Children’s Health Insurance Program, Medicare or Tricare;
- Virginia resident;
- Household income that is below 100% of the Federal Poverty Level;
- Not residing in a long term care facility, mental health facility or penal institution; and
- Screened and meets criteria for Serious Mental Illness (SMI).
Virginia Governor’s Access Plan for the Seriously Mentally Ill (GAP)

- Services include physician visits (includes psychiatrists), mental health services, substance abuse services and medications.

- Services do not include inpatient hospitalization, emergency room visits and transportation.

- GAP includes current DMAS telemedicine coverage.

- Telemedicine may be utilized for the Full Screening for SMI.

www.dmas.virginia.gov
• Under GAP, Magellan offers:
  – Care Coordination;
  – 24/7 Crisis Line;

• Further information about GAP can be found at http://www.dmas.virginia.gov/Content_pgs/gap.aspx.
DMAS web site: www.dmas.virginia.gov

Contact:
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