

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

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Page 1

CHAPTER Service Delivery	CHAPTER 03	SECTION 001	SUBJECT 0105
SECTION Treatment	SUBJECT Telepsychiatry		
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I. APPLICATION:

- SCCCMHA Board
- SCCCMHA Providers & Subcontractors
- Direct-Operated Programs
- Community Agency Programs
- Residential Programs
- Specialized Foster Care
- SUD Providers

II. POLICY STATEMENT:

It shall be the policy of St. Clair County Community Mental Health Authority (SCCCMHA) to provide timely and appropriate telepsychiatry services in accordance with current Medicaid policy.

III. DEFINITIONS:

- A. Telepsychiatry: The use of a real time interactive audio and video communication between a psychiatrist, nurse practitioner, or physician assistant and a person receiving services in order to provide psychiatric care when participants are in different geographical locations.

IV. STANDARDS:

- A. Practitioners must meet the provider qualifications for the covered service provided via telepsychiatry. The practitioner must be licensed, registered, or otherwise authorized to engage in his or her health profession in Michigan (the state where the patient is located) and enrolled in Michigan Medicaid.
- B. Practitioners providing telepsychiatry services through SCCCMHA must have a contract with or be authorized by SCCCMHA.
- C. SCCCMHA and practitioners must ensure the privacy of the individual served and the security of any information shared via telepsychiatry.
- D. The technology used must meet the needs for audio and visual compliance in accordance with current regulations and industry standards. Telecommunication systems using store and forward technology, including asynchronous transmission of medical data, are not approved.

CHAPTER Service Delivery	CHAPTER 03	SECTION 001	SUBJECT 0105
SECTION Treatment	SUBJECT Telepsychiatry		

- E. The room and set up shall provide maximum security.
- F. Standard rules and regulations for keeping medical records, release of medical information and confidentiality, including HIPAA, are applicable to telepsychiatry.
- G. The Treatment Team, in conjunction with the individual receiving services and the caseholder, will determine if telepsychiatry is appropriate.
- H. Informed Consent to Participate in Behavioral Health Telepsychiatry Services (Form #134) shall be obtained prior to the initial appointment. The individual has the right to withdraw the consent at any time and request that appointments be made face-to-face.
- I. Telepsychiatry services are not allowable/billable by Medicare; thus individuals with Medicare are not eligible to participate in telepsychiatry services.
- J. Eligibility to receive (billable) telepsychiatry is to be verified through Primary Care Insurance carrier prior to service provision.

V. PROCEDURES:

IT Department

- 1. Ensures secure, HIPAA-compliant equipment is set up and operational for telepsychiatry sessions.
- 2. Ensures IT staff are available for troubleshooting telepsychiatry equipment or connections whenever needed.

Medical Director/Primary Caseholder

- 3. Identifies an individual who may be appropriate for telepsychiatry services (may be at the request of the individual served).
- 4. Reviews the Informed Consent to Participate in Behavioral Health Telepsychiatry Services (Form #134) with the individual and obtains their signature/consent.
- 5. Notifies schedulers of the need to schedule the appointment for the individual.

Scheduler

- 6. Schedules an appointment with the individual at a mutually convenient date and time.

Telepsychiatry Facilitator

CHAPTER Service Delivery	CHAPTER 03	SECTION 001	SUBJECT 0105
SECTION Treatment	SUBJECT Telepsychiatry		

7. Ensures that the telepsychiatrist has the required information, answers questions from both the individual served and the telepsychiatrist, and assists with follow up and is available during the appointment if assistance is needed.

Telepsychiatrist

8. Conducts telepsychiatry session with individual as they would if they were in person, including documentation, ordering of labs, e-scribing, etc.
9. Consults as needed with other professionals on the treatment team.
10. Consults as needed with Medical Director.

VI. REFERENCES:

Medicaid Provider Manual

VII. EXHIBITS:

- A. Informed Consent to Participate in Behavioral Health Telepsychiatry Services (CMH Form #134)

Individual's Name: _____ **Case Number:** _____

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH

Informed Consent to Participate in Behavioral Health Telepsychiatry Services

In order to receive telepsychiatry services, you and/or the parent/guardian or authorized representative must sign this document. This consent is valid for the entire course of services, until date of discharge or completion of the service. **Instructions:** Please read and review each section of this form. If you need assistance, staff will assist you and answer any of your questions. If you wish to decline this consent, please check the box provided. Your signature at the end of the form indicates your review and consent to the information on the documents. Thank you.

I have been offered behavioral health services via telepsychiatry and understand I will be receiving services or consultation through interactive videoconferencing equipment.

I understand I will be notified as to who is in the room when services or consultation is provided to me when using the videoconferencing equipment.

I understand my privacy and confidentiality is a priority. The equipment used will have security protocols in place to limit the possibility of the videoconference being intercepted.

I understand the healthcare providers at my present location and the remote video site will have access to my health records which include relevant medical information about me including information regarding psychiatric, psychological, HIV, alcohol and/or drug use. I have authorized the use of this information by signing a release of information and this consent to participate in behavioral health telepsychiatry services.

I understand I have the right to stop participating in telepsychiatry services at any time and the consequences of my decision have been explained to me.

Initials

Date

Please Check the Appropriate Box Below:

I have read this document in its entirety and I hereby agree and voluntarily consent by my signature to participate in receiving behavioral health services via telepsychiatry/videoconferencing.

I have read this document in its entirety and I have chosen not to participate in telepsychiatry services or consultation.

Individual/Authorized Representative Signature _____
Date Parent/Guardian Signature _____
Date Date

Witness _____
Date