Department of Social Services

Behavioral Health Telemedicine Proposal

November 2, 2018

DRAFT

Background:
CMS considers telemedicine as a "cost-effective alternative to the more traditional face-to-face way of providing medical care."

Telemedicine may be applicable to medical and/or behavioral health services. For the purposes of this proposal, DSS is exclusively focusing on the behavioral health system.

There are two concurrent stress points in the behavioral health system that can and ought to be alleviated through the use of telemedicine. In the child sector, there is a shortage of child psychiatrists; many of whom refuse to participate in Medicaid or even accept commercial insurance, all of which results in delayed treatment and over-reliance on care solely using medication. In the adult sector, there is an opioid crisis and the system needs more timely access to prescribers of medication such as Buprenorphine.

Telemedicine is rapidly becoming a means by which high quality and lower cost care may be available to more and more of those who struggle with access to healthcare services. Individuals may experience a lack of access to care for multiple reasons, including geography, lack of transportation, medical conditions, disabilities, lack of child or elder care or for several or all of these reasons. Telemedicine may be a means to partially of entirely address each.

Telemedicine is a relatively new paradigm in Connecticut, with its own list of terms, concepts, and procedures:

Proposed Model:

1. A Synchronized Telemedicine model, as defined as, an audio and video telecommunication system that permits real-time communication between the patient and the physician (MD, PA, APRN).
2. DSS is not considering an Asynchronous Telemedicine model, also known as a "store and forward" technology
3. This telemedicine model is not considered a consultation service
4. Telemedicine services will be reimbursable for certain services provided to children and adults with behavioral health conditions
5. The patient must be in a Medicaid enrolled healthcare facility in order to receive telemedicine services.
6. Telemedicine is permissible for medication assessment, medication monitoring, evaluation and individual psychotherapy using the existing procedure codes for these services with a modifier.
7. The following procedure codes are reimbursable under telemedicine for behavioral health services:
    a. E/M

    b. Psychiatric diagnostic evaluation
    c. Individual Psychotherapy
8. All documentation requirement remain in effect, including, but not limited to the start and stop time of the telemedicine session
9. There is no rate differentiation between face to face services and the approved telemedicine services
10. Modifier "GT" or "95" must be used for telemedicine services. The final determination of which modifier will be made by DSS prior to implementation
11. The medical professional billing for telemedicine services must be a CT licensed practitioner and enrolled in Medicaid.
12. There will be no reimbursement for transmission cost
13. Live video conferencing sessions are considered protected health information (PHI) and fall under the scope of HIPAA.

How this works:

- For the purposes of this proposal, the patient is located at the remote or "spoke" site which is a Medicaid enrolled healthcare facility. This could be a school, hospital, nursing home, clinic, primary care office, psychiatric residential treatment facility, etc.
- The MD, PA, APRN is located at a different location or "hub" location
- The synchronized telemedicine service is initiated by the spoke site or "originator site" and the service is rendered meeting the standards of the applicable CPT code billed for the session (e.g. E/M, evaluation, individual psychotherapy)
- The bill is submitted using the applicable CPT code with the designated modifier GT by the performing provider.
- All documentation requirements remain in effect as if the service was done face to face.
- Informed consent from the patient is required

Important Note: Connecticut Medicaid already pays for a different type of telemedicine, econsults, which are an electronic provider to provider electronic consultation. This telemedicine proposal is a very different concept from an econsult.

<u>Questions/Recommendations from providers to date:</u>

1. Can methadone maintenance induction be done via telemedicine? We don't think so
2. Consider home based telemedicine under certain clinical situations (e.g. very stable patient, active patient of the provider, can only be done once without a face to face, etc.)
3. Consider telemedicine for medical services in addition to behavioral health
4. Consider other licensed behavioral health practitioners (e.g. Ph.D., LCSW, etc.)
5. Consider allowing services to be initiated within the home if a clinician initiates the service

<u>Next Steps:</u>

- DSS is still considering if there are certain clinical situations when we would allow a certain provider/type (e.g. behavioral health clinic, ASD provider) to initiate a telemedicine service only when a staff person is with the member in the home. This exception may include telemedicine services to be performed by a broader licensed practitioner cohort (e.g. Ph.D., LCSW, LBCBA)

- DSS will need to meet with state licensing agencies (DCF & DPH) to ensure that all aspects of this proposal remain in compliance with state licensing requirements