ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 9/22

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 Contractors
☐ Residential Programs
☐ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health Authority (SCCCMHA) shall provide timely and appropriate telepsychiatry services in accordance with the current policies of applicable funding sources. .

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), enrolled in Michigan Medicaid, and have current privileges to provide services with SCCCMHA.

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,

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including asynchronous transmission of medical data, are not approved. All technology used must be HIPAA-compliant.

E. The room and set up shall provide maximum privacy and information 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. Eligibility to receive (billable) telepsychiatry is to be verified through Primary Insurance carrier prior to service provision. Verification shall be completed by a CMH Finance Staff/designee.

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 when 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.

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Telepsychiatry Facilitator

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:

A. Medicaid Provider Manual

VII. EXHIBITS:

A. Informed Consent to Participate in Behavioral Health Telepsychiatry Services

VIII. REVISION HISTORY:

Date issued 03/19, 03/20, 3/21.

EXHIBIT A

Individual's Name: _____ Case Number: _____

St. Clair County Community Mental Health Authority

Informed Consent to Participate in Behavioral Health Telepsychiatry Services

In order to receive telepsychiatry services, informed consent is needed. 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 have questions or need assistance, staff can assist you. 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 HIPAA-compliant 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.

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

_____ _____

Witness | Date