# Telepsychiatry

Adapted from the APA Resource Document on Telepsychiatry, approved by the APA Board of Trustees July 1998

## I. INTRODUCTION

Telemedicine is an enabling technology, originally developed to enhance access to health care for rural and underserved populations. With the development of more technology and increasing experience, it has become evident that the goal of telemedicine is much broader. Telemedicine- and by extension telepsychiatry- is becoming more widespread, less costly, and may demonstrate greater efficiency, continuity, and timeliness in the provision of medical care. The widening scope of applications now includes hospice, support groups, substance abuse and behavioral health screenings, remote consultations that obviate language or cultural barriers, and telepsychiatric care of the deaf mentally ill via American Sign Language. Increased use of the internet for medical care implies that the computerized patient record, patient access to vast amounts of medical information, and provider access to patients anywhere in the world through the use of the internet will likely modify the practice of psychiatry and the doctor-patient relationship as we have known it. At this time there is limited experience upon which to base clinical guidelines. Nevertheless, we must begin to address the issues. While we await more data, the following guidelines are proposed, mindful that these guidelines will be modified as the field of telepsychiatry develops.

## I. DEFINITION

Telepsychiatry is the use of electronic communication and information technologies to provide or support clinical psychiatric care at a distance. This definition is paraphrased from the National Library of Medicine. It is the intent of this guideline to focus on the live, interactive two-way audio-video communication technology- videoconferencing. Videoconferencing has become synonymous with telepsychiatry involving patient assessment and clinical care at a distant location.

## II. CLINICAL APPLICATIONS

1. **Scope**

Clinical applications encompass diagnostic, therapeutic, and forensic modalities across the age span. The technology appears applicable to a broad range of diagnoses, although suitability for a specific patient may depend on the individual needs of the patient at the time. Points of delivery include hospitals and their emergency rooms, clinics, offices, homes, nursing homes, schools, and prisons.

2. **Clinical Interview**

Telepsychiatry may be conducted between physicians in consultation, between health care team members, or between mental health providers and a patient. The consulting clinician's role must be clearly defined, and the patient needs to be clear as to whom is responsible for his/her care. The referring and consulting providers should clarify who

will be communicating results of the interview to the patient. If the provider is to be the treating clinician for the patient at a distance, it is helpful for them to have a working relationship with the local mental health providers; in this way the patient has available a full continuum of care which can be directed even at a distance. Availability of the treating clinician, at times other than those scheduled, should be addressed as in any practice setting.

3. **Emergency Evaluations**
In general, behavioral health emergencies such as suicidal, homicidal, and acutely psychotic patients should not be managed via telepsychiatry. If there is no other option available, telepsychiatry could be utilized while other options are pursued. In that instance support staff or responsible family members should be available at the remote site. A provider who provides telepsychiatry to remote locations should be responsible for considering options if acute hospitalization of the patient is indicated. At a minimum, resources in the patient's immediate area should be identified and documented, and the patient informed of those options.

4**. Other Uses of Telepsychiatry**
Telepsychiatry has other applications including, but not limited to, forensic evaluations, disability determinations, and assessments of fitness for duty and return to work evaluations. It is also expected that telepsychiatry will become an important component in the use of distance learning, research, clinical supervision, and administration.

## III. PRIVACY, CONFIDENTIALITY, AND INFORMED CONSENT

Patients have a right to privacy and confidentiality of communication, and many states recognize a higher confidentiality standard for psychiatric records. Evaluation or treatment must be performed in an environment where there is a reasonable expectation of absence from intrusion by individuals not involved in the patient's direct care. Hospital or clinic staff involved in the patient's care, family members, of telemedicine staff may at times be present in interviews. Patients should be informed about others present in the room at a distant site, if such persons are off camera. Equipment should utilize decoding/encoding technology and/or transmission over secure lines.

As with any procedure, the patient must be aware of the potential risks and consequences as well as the likely benefits of telemedicine consultation, and must be given the option of not participating. Patients should be informed that care would not be withheld if the telepsychiatric encounter were refused, although such care could depend on the availability of alternative resources.

## IV. MEDICAL RECORDS

Medical records of telepsychiatric interventions are to be maintained as with psychiatric interviews in general. If the quality of the transmission was poor, or equipment failure prevents an adequate assessment, this should be documented in the patient record. Telepsychiatric care is subject to Quality Assurance monitoring as with other forms of

psychiatric care; procedures should be systematically monitored and evaluated as part of overall quality improvement of a facility.

## V. LICENSURE, LIABILITY, AND TRAINING

Provider licensing requirements may vary from state to state. The provider must establish with the state board of that specialty area in that patient's state whether a license is required from that state in order to provide telepsychiatric services. Interstate use of telepsychiatry may require multi-state licensing unless a national telemedicine license is developed.

The provider should establish with his malpractice carrier whether coverage is provided for interstate use of telepsychiatry.

Training for clinical applications should include familiarity with the equipment, its operation and limitations, and means of safeguarding confidentiality, security, and safety. Providers have an obligation to stay current with the technology and its uses through continuing education.

## VI. EQUIPMENT FOR VIDEOCONFERENCING

Selection of equipment should be based on ease of use, image and sound quality, cost, and suitability to expected applications. The major components may include monitors, cameras, CODEC (coder-decoder), desktop computer, microphones, speakers, videophones, and other technologies as they are developed. The equipment chosen should be adequate to obtain the results expected with a good evaluation or treatment done in a traditional setting. This should be a part of ongoing Quality Assurance monitoring.

## VII. REIMBURSEMENT

Reimbursement for Telepsychiatry should follow customary charges for the delivery of the appropriate outpatient CPT code. Only those services currently covered in an office or outpatient setting will be allowed for payment.

The covered CPT Codes are:
Office and Outpatient visits (99201-99215)
Psychiatric Diagnostic Interview (90801)
Individual Psychotherapy Services (90804-90809)
Pharmacologic Management (90862)
Consultations (99241-99245)

An additional structure for reimbursement of collateral charges, e.g. technician time and line time, may be identified and considered as a component of Telepsychiatry.