Clinical Policy Title: Telepsychiatry

Clinical Policy Number: 10.02.08

Effective Date: April 1, 2018
Initial Review Date: November 16, 2017
Most Recent Review Date: March 6, 2018
Next Review Date: March 2019

Related policies:
CP# 18.01.02 Telehealth

ABOUT THIS POLICY: AmeriHealth Caritas has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas’ clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by AmeriHealth Caritas when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas’ clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas’ clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas will update its clinical policies as necessary. AmeriHealth Caritas’ clinical policies are not guarantees of payment.

Coverage policy

AmeriHealth Caritas considers the use of telepsychiatry to be clinically proven, and therefore medically necessary, when all of the following criteria are met:

1. A mental health diagnosis is documented.
2. A secure, two-way, real-time interactive telecommunication system is used.
3. A licensed health care provider with experience in mental health treatment is recommended to be present with the patient at the originating site.
4. A physician licensed in the state where the patient resides must render the service, and be located at the distant site.
5. Medical records of each session are maintained.

Telepsychiatry services considered medically necessary include assessment and diagnosis, psychotherapy, and medical management (APA, 2010).

Limitations:

Policy contains:
- Mental health telemedicine.
- Telemental health.
- Telepsychiatry.
- Videoconferencing telepsychiatry.
Phone-based services, remote medical monitoring devices, virtual reality devices, and internet-based services such as Skype and chat rooms are not considered interactive telecommunication systems, and thus not medically necessary telepsychiatry services.

Group or family psychotherapy from providers at different sites is not considered a necessary telepsychiatry service.

**For Medicare Members:**

Any telepsychiatry services will only be covered by Medicare if it is provided outside a Metropolitan Statistical Area, as access to mental health care is often limited in rural areas.

**Alternative covered services:**

Various mental health services delivered in person by the provider to the patient.

**Background**

One form of telehealth is telepsychiatry, which entails mental health services by videoconference, including assessment, treatment, education, monitoring, and collaboration. Telepsychiatry is also referred to as telemental health, and is closely related to telepsychology and telepsychotherapy. Various locations can accommodate telepsychiatry, including hospitals, clinics, nursing facilities, schools, prisons, and homes. Providers can include psychiatrists, psychologists, nurse practitioners, physician assistants, and social workers (Grady, 2009).

The technique is not new, but its use has soared since the development of technology that accommodates telepsychiatry, starting in the 1990s (Gajaria, 2015). Telepsychiatry can include assessment and diagnosis, psychotherapy, and medical management.

According to the American Telemedicine Association, telepsychiatry offers a variety of benefits to the patient. It can improve continuity of care between facilities, be especially helpful to remote and underserved patients, and provide “distance” that is especially helpful for post-traumatic stress disorder, agoraphobia, and eating disorders. Telepsychiatry programs have been used for adults, and also for children and adolescents in clinics, community mental health centers, schools, day care, prisons, and private practice (Grady, 2009).

The American Medical Association recommends that individual specialty groups develop their own telemedicine practice guidelines (AMA, 2014). Accordingly, the American Psychiatric Association, which had previously created a telepsychiatry work group, produced a written and video toolkit covering over 20 key topics on issues of training, clinical practice, legal, and reimbursement (Varrell, 2016).
The American Psychiatric Association’s first guideline on telepsychiatry was published in 1998; the most recent version was approved by the group’s board of directors in 2010. The Association characterizes the service as a live, interactive two-way audio-video communication technology, or videoconferencing. It also addresses points of delivery, presence of providers, maintaining records, and privacy (APA, 2010).

The American Psychological Association’s Joint Task Force produced guidelines on telepsychology in 2013, which included seven recommendations directed at psychologists. Included in these recommendations are competence in telepsychology, maintaining care standards, ensuring informed consent, and ensuring data confidentiality and security (Joint Task Force, 2013). Another set of guidelines for establishing a telemental health program includes structural issues like community partnerships, Memoranda of Understanding, and videoconferencing software (Jones, 2014).

Guidelines can exist for subsets of telepsychiatry patients. One example is a set of recommendations for emergency telepsychiatry, developed by researchers from the rural western U.S. and Australia (Shore, 2007). The American Academy of Child and Adolescent Psychiatry issued a lengthy guideline addressing telepsychiatry for young persons (Myers, 2008). There is a belief that stronger and more updated guidelines are needed for telehealth in children (Hilty, 2016), along with better-defined measures of effectiveness (Comer, 2016).

The Centers for Medicare and Medicaid Services defines telehealth as a service other than a face-to-face meeting with the patient, provided outside any Metropolitan Statistical Area, due to the difficulty in accessing needed care in rural areas. Medicare coverage for telehealth services includes psychiatric diagnostic interview examination, individual psychotherapy, neurobehavioral status exam, individual group health and behavior assessment and intervention, and 15-minute annual depression screening.

Medicare coverage only applies if the service takes place in a physician/practitioner office, hospital, rural health clinic, federally qualified health center, skilled nursing facility, hospital-based dialysis center, or community mental health center. Reimbursement can be claimed by physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists, clinical social workers, and registered dietitian/nutrition professionals. Clinical psychologists and social workers cannot bill for psychotherapy services that include a medical examination and management (ATA, 2013).

**Searches**

AmeriHealth Caritas searched PubMed and the databases of:

- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
- The Centers for Medicare & Medicaid Services (CMS).
We conducted searches on October 27, 2017. Search terms were: “telepsychiatry,” “telehealth AND psychiatry,” “telemedicine AND psychiatry,” “telehealth AND psychotherapy” and “telemedicine AND psychotherapy.”

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.

- **Guidelines based on systematic reviews.**

- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

Evaluating the effectiveness of telepsychiatry employs various measurements. An assessment of 452 studies identified six commonly used measures, including satisfaction, reliability, treatment outcomes, implementation outcomes, cost effectiveness, and legal issues (Hubley, 2016).

The number of publications assessing efficacy of telehealth for mental health services is growing. One review found that 56 percent of scientific articles on child telehealth in the 15-year period (2000 – 2014) were published in the most recent five years. Some health systems, such as the Indian Health Service, now rely heavily on telemental health (Shore, 2012). Despite this growth, more knowledge is needed about when, under what circumstances, and for whom telemental health is most indicated (Comer, 2016). In general, the number of systematic reviews and meta-analyses (and randomized controlled trials) has been limited, despite the growing popularity of telemental health.

Early reviews suggested that telepsychiatry obtained similar results from face-to-face encounters (Garcia-Lizana, 2010). An article containing 10 systematic reviews concluded that good evidence existed of effectiveness (reliability and improved outcomes) and feasibility (use, satisfaction, and cost) for videoconference-based telepsychiatry, despite heterogeneous data that makes comparisons difficult (Chipps, 2012).

More recent systematic reviews and meta-analyses tend to show that telepsychiatry produces similar or better results compared to face-to-face encounters. A recent systematic review of 12 studies determined that neurocognitive test scores administered to adults with and without psychiatric disorders were similar, regardless of whether the scores were obtained through teleconferencing or on site (Brearly, 2017).
A meta-analysis of 18 studies (n=823) comparing remote vs. face-to-face treatments of obsessive compulsive disorder observed that remote therapy decreased symptoms of a large magnitude; was more effective than controls; and had similar outcomes to face-to-face treatment. Even low-intensity remote methods produced a decrease in symptoms similar to higher-intensity therapy (Wootton, 2016).

A systematic review of 20 studies (n=1,191) analyzed dropout rates from psychotherapy treatment by soldiers who had served in the Iraq and Afghanistan wars and suffered from post-traumatic stress disorder. While the overall pooled dropout rate was 36 percent, there was no difference between those who were treated in person or by using telemedicine individuals eligible (Goetter, 2015). Another review of post-traumatic stress disorder in 11 studies (n=472) showed short term (one to six months) improvements after telepsychology (internet and video-based interventions) in cognitive and behavioral depression symptoms, generalized anxiety, and post-traumatic stress. A comparison with face-to-face encounters could not be made (Bolton, 2015).

A meta-analysis of five studies (n=342) of telepsychology used in criminal justice subjects and substance abusers found mental health symptoms, therapeutic processes, program engagement, program performance, and service satisfaction, were similar to those treated in person (Batastini, 2016).

A systematic review of 65 articles on videoconferencing psychotherapy addressed 10 issues, including therapeutic types/formats that have been implemented, populations with which the service is being used, number and types of publications related to the service, and available satisfaction, feasibility, and outcome data. Videoconferencing psychotherapy was deemed to be feasible, was used in various therapeutic formats and with diverse populations, was associated with good user satisfaction, and was found to have similar clinical outcomes to face-to-face psychotherapy (Backhaus, 2012).

Reviews of telepsychiatry are sometimes focused on a particular level or setting of care. One systematic review of 23 studies concluded that in acute care facilities, use of telepsychiatry is associated with high patient satisfaction, reduced admissions to psychiatric inpatient units, quality of clinical interaction is similar to that in face-to-face care, and is cost effective (Salmoiraghi, 2015). Another review of eight studies, of varying quality, determined that telepsychiatry had no effect on inpatient readmission rates in psychiatric settings (Koblauch, 2016).

A systematic review of 14 studies from 2004 – 2014 comparing telehealth with face-to-face care for psychotherapy generally show comparable treatment satisfaction as well as similar ratings of therapeutic alliance. The authors noted a potential for decreased patient comfort with aspects of group treatment delivered via telehealth (Jenkins-Guarnieri, 2015).

A Hayes review explored results of home-based telemental health for elderly persons with major depressive disorder, taken from 14 studies, two of which were systematic reviews/meta-analyses, and nine of which were randomized controlled trials. The study presented conflicting findings; in some studies, videoconferencing was superior to face-to-face treatment in reducing symptoms, while others showed no significant differences (Hayes, 2017).
Among the randomized controlled trials on telepsychiatry, one divided 30 obsessive-compulsive disorder patients into three evidence-based exposure and response prevention treatment groups for 12 weeks. Patients rated videoconference assisted treatment to be natural and reported strong working alliances with their therapists, and produced significantly greater reductions in symptoms than did the self-help and waiting list groups (Vogel, 2014).

Policy updates:

None.

Summary of clinical evidence:

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brearly (2017)</td>
<td>Key points:</td>
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</tbody>
</table>
| Mental telehealth effect on neurocognitive test scores | - Systematic review of 12 studies, adults 34 – 88 with or without psychiatric disorders.  
- Verbally-mediated tasks (digit span, verbal fluency, and list learning) were not affected by videoconference administration, compared to on-site services.  
- Videoconference scores for untimed tasks and those allowing for repetition fell slightly below on-site scores.  
- Recommends developing clinical best practices for conducting neuropsychological assessments via videoconference. |
| Hubley (2016)          | Key points:                        |
| Commonly used measures in evaluating telepsychiatry | - Systematic review of professional literature, 452 articles included.  
- Six major categories of evaluation were 1) satisfaction, 2) reliability, 3) treatment outcomes, 4) implementation outcomes, 5) cost effectiveness, and 6) legal issues.  
- Patients and providers generally satisfied with telepsychiatry, but providers more concerned about potentially adverse effects of telepsychiatry on therapeutic rapport.  
- Telepsychiatry comparable to face-to-face services for reliability of clinical assessments and treatment outcomes. |
| Wootton (2016)         | Key points:                        |
| Comparison of remote and face-to-face therapeutic effects on obsessive-compulsive disorder | - Meta-analysis of 18 studies (n=823) on treatment of obsessive compulsive disorder.  
- Remote treatment produces a decrease in symptoms of a large magnitude.  
- Remote treatment is more effective than control.  
- Remote treatment outcomes are not significantly different than face-to-face.  
- Low intensity and higher-intensity methods produce a large decrease in symptoms. |
| Salmoiraghi (2015)     | Key points:                        |
| Telespsychiatry effect in acute care facilities | - Systematic review of 23 studies, on use of telepsychiatry in acute settings.  
- Patients have a positive attitude and high satisfaction of telepsychiatry.  
- Use of telepsychiatry is associated with fewer admissions to psychiatric inpatients units.  
- Telepsychiatry appears to be cost-effective. |
<p>| Backhaus (2012)        | Key points:                        |</p>
<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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</thead>
</table>
| Issues in videoconferencing psychotherapy | • Review of 65 articles on videoconferencing psychotherapy.  
• Videoconferencing was judged to be feasible, and has been used in multiple formats with diverse populations.  
• Videoconferencing has good user satisfaction, and has similar clinical outcomes compared to face-to-face psychotherapy. |

**References**

**Professional society guidelines/other:**


**Peer-reviewed references:**


**CMS National Coverage Determinations (NCDs):**

No NCDs identified as of the writing of this policy.

**Local Coverage Determinations (LCDs):**

No LCDs identified as of the writing of this policy.

**Commonly submitted codes**

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

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<td>Psychotherapy, 30 minutes with patient</td>
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<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient</td>
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<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
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<td>90845</td>
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<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)</td>
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<td>F40.9</td>
<td>Phobic anxiety disorder, unspecified</td>
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<td>F25.0-F25.9</td>
<td>Schizoaffective disorder</td>
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