

Behavioral Health Issues for Rural Health Clinics

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2017 Kentucky Rural Health Clinic Summit

Kentucky Office of Rural Health and UK Center of Excellence in Rural Health



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Behavioral Health Basics

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[The Problem]

- There is an increasing incidence of behavioral health problems both for mental health and substance use disorders

Death rates from prescription opioid pain reliever overdoses quadrupled from 1999-2010, and heroin overdoses increased as well.

- There is an increasing shortage of behavioral health professionals

60% of rural Americans live in mental health professional shortage areas.



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration. (2012). Designated Health Professional shortage Areas (HPSA) Statistics, Office of Shortage Designation.
Rudd, et al, "Increases in Heroin Overdose Deaths – 28 States, 2010 to 2012," CDC Morbidity and Mortality Weekly Report

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[The Problem]

From 1996 to 2010, the death rates from suicide among children, teens and young adults were double in rural communities compared to urban ones.

Rural populations experience an 18% higher rate of depression than urban populations.

Source: Fontanella, Hiance-Steelesmith, Phillips, et al. "Widening Rural-Urban Disparities in Youth Suicides, United States, 1996-2010"
JAMA Pediatrics, May 2015
1999 National Health Interview Survey



[The Problem]

The death rate for 28 states (including Kentucky) for heroin overdose more than doubled between 2010 and 2012, increasing from 1.0 per 100,000 to 2.1 per 100,000.

Kentucky alone reported a 279% increase in heroin deaths from 2010 to 2012.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration. (2012). Designated Health Professional shortage Areas (HPSA) Statistics, Office of Shortage Designation.
Rudd, et al, "Increases in Heroin Overdose Deaths – 28 States, 2010 to 2012," CDC Morbidity and Mortality Weekly Report



[The Problem]

In addition to overdoses, Kentucky, Tennessee, Virginia and West Virginia have seen a 364% increase in the number of cases of acute Hepatitis C Virus infections between 2006 and 2012.

Source: Rudd, et al, "Increases in Heroin Overdose Deaths – 28 States, 2010 to 2012," CDC Morbidity and Mortality Weekly Report



[The Problem]

- In these four states – Kentucky, Tennessee, Virginia and West Virginia:
 - During 2011–2012, the proportion of heroin admissions increased (from 8.6% to 12.0%) at the same time as the proportion of prescription opioid admissions decreased.
 - In 2012, 3 out of 4 persons who used heroin and prescription opioids in the past year reported prescription opioid misuse before initiating heroin.
 - In ten years, the number of persons reporting heroin dependency more than doubled, from 214,000 in 2002 to 467,000 in 2012.

“The concomitant increase in the proportion of treatment admissions for prescription opioid abuse, heroin abuse, and the number of admitted patients who report injecting suggests that the increase in acute HCV infections in central Appalachia is highly correlated with the region's epidemic of prescription opioid abuse and facilitated by an upsurge in the number of persons who inject drugs in these four states.”

What is Behavioral Health?

- Behavioral Health is an umbrella term that includes both mental health disorders and substance use disorders



Behavioral Health - History

- The Diagnostic and Statistical Manual of Mental Disorders V, published in 2013, uses the term “substance use disorder” to classify what had originally been termed “substance abuse” and “substance dependence.”
- International Classification of Diseases and Related Health Problems, Tenth Revision (“ICD-10”) combines Mental, Behavioral and Neurodevelopmental Disorders in Chapter 5
- Part of these revisions are meant to alleviate stigma that is a barrier to accessing care

Behavioral Health - Stigma

A barrier to treatment is the stigma attached to behavioral health disorders, which is expressed through language and terminology:

Then – Stigma and Individual-Focused	Now – Disorder-Focused
Addict	Substance Use Disorder
Alcoholic	Substance Use Disorder
Substance Abuse	Substance Use Disorder
Crazy	Mental Health Disorder
Insane	Mental Health Disorder

Behavioral Health – Challenges for RHCs

- There are four main barriers to behavioral healthcare, and these should be the backbone of any policy to address behavioral health in a rural setting
- They are known as the “Four A’s”

Behavioral Health – Barriers to Care

- **Availability** includes the staffing or service shortages limiting the receipt of services
- **Accessibility** addresses the knowledge of when and where to obtain services, including coordination of services across sectors of the health and social service system, as well as the travel issues which may be involved
- **Affordability** involves the costs associated with receiving care and availability of benefits/insurance to offer services, and
- **Acceptability** incorporates the persistent issues related to the negative perception and stigma attached to the need for services

Mental Health

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[The Problem]

The CDC estimates that approximately 25% of adults nationwide have a mental illness or diagnosable mental disorder.

50% will at some point experience mental illness in their lifetime.

Source: Centers for Disease Control and Prevention, 2011

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Mental Health

Because of the scarcity of mental health providers, rural Americans are more likely to use primary care physicians for their behavioral health needs, which is why integration of behavioral health services into RHCs is so important.

Source: U.S. Department of Health and Human Services. (2005). Mental health and rural America: 1994–2005. Rockville, MD: Office of Rural Health Policy, Health Resources and Services Administration.

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Substance Use Disorder

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[The Problem]

- A study in 1999 noted that “at least 15 million rural residents struggle with significant substance dependence, mental illness, and medical-psychiatric comorbid conditions.”
- Opioid use has seen a staggering change in 50 years, with a recent study showing that recent opioid users lived overwhelmingly in non-urban areas (75.2%) and were introduced to opioids through prescription drugs (75%).

Sources: Roberts, Battaglia, & Epstein, Frontier ethics: mental health needs and ethical dilemmas in rural communities, 1999
Cicero, Ellis, Surratt, & Kurtz, The changing face of heroin use in the United States: a retrospective analysis of the past 50 years



Substance Use Disorder - Accessibility

- Kentucky's approach to treating SUD has been a mixed bag
 - Suboxone – this opioid treatment drug is at the center of a storm of controversy
 - The Kentucky Board of Medical Licensure has established incredibly strict provisions for the prescribing of Suboxone to curb abuse of the therapy drug and to prevent doctor shopping, but this can lead to high compliance burdens that paradoxically drive providers away due to low reimbursement rates
 - To combat opioid abuse, Kentucky has been tightening regulations prescribing for physicians, but also increasing regulation of physicians who prescribe medication for substance use disorder treatment
 - HB 333 – designed to curb fentanyl abuse
 - Limits prescription of Schedule II drugs to a three-day supply if they are intended to treat acute pain
 - Schedule II drugs include oxycodone, hydrocodone and fentanyl

Substance Use Disorder - Accessibility

- While Kentucky's regulations have tightened, the federal government has worked to expand access to treatment options
 - The DEA has expanded the number of patients that a physician may prescribe Suboxone for under a DATA waiver, as well as the types of prescribers (Final Rule is in 42 C.F.R. 8, part of the Comprehensive Drug Addiction and Recovery Act of 2016)
 - Prescribing authority has been extended to Nurse Practitioners and Physician Assistants under the DATA Waiver program
 - No specific regulatory authority currently in Kentucky for Mid-level prescribing

Behavioral Health in RHCs- What You REALLY Need to Know

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Behavioral Health in RHCs – Basics

- Behavioral health services are covered when provided by RHCs
- 907 KAR 1:082 – Coverage Provisions and Requirements Regarding RHCs--Medicaid
 - Treatment for mental health disorders, substance use disorders and co-occurring mental health and substance use disorders are all covered services



Behavioral Health in RHCs – Basics

- Medicaid covered services include (through various delineated practitioners):
 - Screenings
 - Assessments
 - Psychological testing
 - Crisis intervention
 - Service planning
 - Individual outpatient therapy
 - Family outpatient therapy
 - Group outpatient therapy
 - Collateral outpatient therapy
- Screening, brief intervention, and referral to treatment for a substance use disorder
- Day treatment
- Comprehensive community support services
- Intensive outpatient program
- Therapeutic rehabilitation program services

Integrating Behavioral Health – Reimbursable Behavioral Health Providers under Kentucky Medicaid

Types of behavioral health providers who are eligible to provide reimbursable services in an RHC under Medicaid (per 907 KAR 1:082):

- A licensed psychologist
- A physician
- A psychiatrist
- A licensed professional clinical counselor
- A licensed clinical social worker
- A licensed marriage and family therapist
- An advanced practice registered nurse
- A licensed psychological practitioner
- A licensed psychological associate working under the supervision of a licensed psychologist
- A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor
- A certified social worker working under the supervision of a licensed clinical social worker
- A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist
- A physician assistant working under the supervision of a physician
- A licensed professional art therapist
- A licensed professional art therapist associate working under the supervision of a licensed professional art therapist

Integrating Behavioral Health – Reimbursable Behavioral Health Providers under Medicare

Types of behavioral health providers who are eligible to provide reimbursable services in an RHC under Medicare (per the Medicare Benefits Policy Manual) include:

- Clinical Psychologists (CP);
- Clinical Social Workers (CSW), (also referred to as Licensed Clinical Social Workers, or LCSWs);
- Doctoral level clinical psychologists;
- Nurse Practitioners with proper behavioral health training;
- Certified Nurse Midwives;
- Physicians Assistants;
- Physicians with proper behavioral health training

Behavioral Health in RHCs – Basics

- Medicare Benefit Policy Manual:

A RHC or FQHC visit is defined as a medically-necessary medical or ***mental health visit***, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, nurse practitioner, physicians assistant, certified nurse midwife, clinical psychologist or a clinical social worker during which time one or more RHC or FQHC services are rendered.

- As opposed to Medicare, covered Medicaid behavioral health treatment visits may happen in a group setting, such as family or group outpatient therapy

Integrating Behavioral Health – Benefits

- In addition to medical problems, a patient may have behavioral health issues contributing to the same or different issues. These problems can be identified and a comprehensive care plan can be coordinated using a team approach.
- Typically, primary care providers are not well versed in the diagnosis and treatment of behavioral health problems, thus the addition of the behavioral health provider provides an improved level of expertise.

Source for Integration of Behavioral Health in to RHC Practice slide content:

“Incorporating Behavioral Health Services in the Rural Health Clinic,” National Organization of State Offices of Rural Health, 2016

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Integrating Behavioral Health – Benefits



- Chapter 13 of the Medicare Benefits Policy Manual specifically states that medical and behavioral health providers may be reimbursed for services performed on the same day at the same location in the RHC. This generates revenue for the RHC and provides convenience and a more holistic experience for the patient.
- Patients have access to behavioral health services in a familiar environment without the stigma of visiting a practice specific to behavioral health.

Integrating Behavioral Health

- A mental health visit is a medically-necessary visit between a RHC or FQHC patient and a RHC or FQHC practitioner during which time one or more RHC or FQHC mental health service is rendered
- Services furnished must be within the practitioner's state scope of practice
- Group mental health services do not meet the criteria for a one-one-one, face-to-face encounter in a FQHC or RHC under Medicare, but Medicaid allows for a wider range of treatments

Integrating Behavioral Health – Two Categories

Behavioral health services in the primary care setting fall into two broad categories:

- I. The first category involves services designed to address the needs of patients with a specific behavioral health diagnosis.
 - a) These services include
 1. psychiatric diagnoses and assessment;
 2. patient, family, and group psychotherapy;
 3. medication management;
 4. crisis psychotherapy;
 5. psychoanalysis; and
 6. transitional management services.
 - b) These services are billed using psychiatric current procedural terminology (CPT) codes or evaluation and management codes. The specific code used will depend on the service provided and the credentials of the servicing provider.

Integrating Behavioral Health – Two Categories

Behavioral health services in the primary care setting fall into two broad categories (cont'd):

- I. The second behavioral health services category includes health and behavioral assessment and intervention (HBAI) services. HBAI services are services provided to patients not diagnosed with a psychiatric problem, but whose cognitive, emotional, social, or behavioral functioning affect prevention, treatment, or management of a physical health problem including chronic health issues (e.g., diabetes, obesity, or hypertension)
- II. Examples of HBAI services include work with patients on issues related to medication compliance, diet, stress issues, smoking cessation, etc.

Integrating Behavioral Health – Where to Begin

- Decide what your goals are and prioritize them
 - Expand access to mental health services?
 - Provide direct care vs. consultative services for PCPs
 - Improve primary care provider productivity?
 - Improve coordination of care?
- Determine the best ways to achieve each goal
 - Start simply and evolve with experience
 - Avoid competition for necessary resources



Integrating Behavioral Health – Where to Begin

- Understand mental health reimbursement policies
 - Understand the mental health procedure and diagnostic codes and managed care systems (e.g., prior authorization, limitations on numbers of visits, paperwork requirements, etc.)
 - Recognize which types of providers are reimbursable by payers
 - Recognize the different requirements for behavioral health services versus physical health services
- Focus on services that are reimbursable
- Understand different treatment models

Behavioral Health in RHCs- Change in Scope

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Integrating Behavioral Health – Change of Scope

- 907 KAR 1:055 – Section 10
 - An RHC can submit a change in scope request to DMS whenever it adds a covered service or increase in frequency of a covered service, or if there is a statutory/regulatory change that materially impacts the costs or visits of an RHC
 - The threshold is a that such a change in scope must result in a minimum of a 5% increase (or decrease) in the existing final PPS rate
 - **The bottom line is that the addition of behavioral health services to an RHC practice may result in an increased PPS rate**

[Integrating Behavioral Health – Change of Scope]

- Change in scope documentation:
 - A narrative describing the change in scope;
 - A completed MAP 100501, Prospective Payment System Rate Adjustment, completed according to the Instructions for Completing the MAP 100501 Form; and
 - A signed letter requesting the change in scope.

Behavioral Health in RHCs- Substance Use Disorder Treatment

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Behavioral Health in RHCs – SUD Treatment Medication-Assisted Therapies

- One of the more highly-effective treatments of opioid abuse is the use of Medication-Assisted Therapies (“MATs”) such as Suboxone
- Congress approved the Drug Addiction Treatment Act in 2000 to provide physicians more independence to prescribe buprenorphine to treat opioid addiction through a waiver process (DATA-waiver)
- Kentucky Board of Medical Licensure has issued strict regulations with regard to the prescribing of these substances
 - As mentioned earlier, these regulations tend to REDUCE the number of providers using MATs, as low reimbursement rates and high compliance burdens send providers to more lucrative locations or practice areas

Behavioral Health in RHCs – SUD Treatment Medication-Assisted Therapies

- 201 KAR 9:270 requirements for Suboxone:
 - Physician must document extensive information about the patient and his or her medical history
 - Physician must perform certain tests, obtain KASPER reports, perform a physical exam, diagnose the patient to be in opioid withdrawal, educate the patient about the treatment, and obtain extensive consent to the treatment
 - After initial administration of the drug, the physician must then develop and implement a treatment plan of objective behavioral modification and a series of follow-up examinations at graduated intervals
 - Physician must make determinations on the continuation of treatment every three months and document medical necessity every twelve months

Behavioral Health in RHCs – SUD Treatment Medication-Assisted Therapies

- 201 KAR 9:270 requirements for Suboxone (cont'd):
 - Physician must obtain at least eight drug screens from the patient during the twelve months, and two must be random and include a pill count
 - At the end of the twelve-month interval, if the daily therapeutic dose exceeds the equivalent of sixteen milligrams of buprenorphine (Suboxone) per day and the physician is not board-certified in addiction medicine, the physician must refer the patient to another physician who IS certified by an addiction medicine board
- Not only are the KBML prescribing regulations tough, but pharmacists have discretion to refuse to fill the prescription
- Federal law limits the number of patients that may be treated this way - 30 in the first year, and a maximum of 275 thereafter (if a waiver was held for 100 patients for a minimum of a year)

Behavioral Health in RHCs – SUD Treatment Medication-Assisted Therapies

- July 22, 2016 – President Obama signed the Comprehensive Addiction and Recovery Act (“CARA”) into law, and a Final Rule was issued on August 8, 2016
 - Expands access to substance abuse treatment services and overdose reversal medications by expanding federal privileges to prescribe buprenorphine to qualifying nurse practitioners (“NPs”) and physician assistants (“PAs”) until Oct. 1, 2021
 - NPs and PAs must complete 24 hours of training to be eligible for the waiver
 - In Kentucky, NPs are regulated by the Kentucky Board of Nursing, which is working to promulgate regulations on prescribing standards; these standards will likely be similar to the those enacted by the Kentucky Board of Medical Licensure

Behavioral Health in RHCs – SUD Treatment Medication-Assisted Therapies

- In Kentucky, Nurse Practitioners are regulated by the Kentucky Board of Nursing, which is working to promulgate regulations on prescribing standards; these standards will likely be similar to the those enacted by the Kentucky Board of Medical Licensure
- NPs will have to meet both federal and state standards and form a Collaboration Agreement with a provider



Behavioral Health in RHCs – SUD Treatment Documentation

If it isn't written down, it didn't happen.



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Behavioral Health in RHCs – SUD Treatment Documentation

- Both Kentucky and the federal government have separate recordkeeping requirements for substance use disorder treatments
- DEA requirements:
 - Buprenorphine treatment records should include a:
 - Patient Log which identifies patient by name or ID number
 - Name of drug prescribed or dispensed for the purposes of SUD treatment
 - Strength and quantity of the medication prescribed for the SUD treatment
 - Date of issuance of the prescription
 - This is best done by keeping a photocopy of the prescription with the patient's record
 - Records should be kept for 2 years
 - The DEA recommends keeping SUD treatment records separate, but it is not required

Behavioral Health in RHCs – SUD Treatment Documentation

- Kentucky documentation requirements (201 KAR 9:260 and 270 and KBML Guidelines):
 - Appropriate medical history relevant to the medical complaint and past medical history
 - Including history of substance abuse or any prior treatment for substance abuse including psychosocial
 - Documentation of Physical Examination
 - Documentation of Treatment Plan
 - Obtain KASPER Report (for a 12-month period) and document in record accordingly
 - Document medical necessity to prescribe and dispense SUD treatment drugs
 - Patient consent to treatment
 - Clinic Policy regarding prescribing of controlled substances/SUD treatment medications
 - Controlled substance contract with patient

Behavioral Health in RHCs – SUD Treatment Documentation (Continued)

- Specifically, 201 KAR 9:270 lists the following documentation requirements
 - The patient's history of present illness
 - Patient's history of substance abuse
 - Patient's social and family history
 - Patient's past medical and psychiatric histories
 - Physical examination of patient
 - Patient's injection use history which includes screening for HIV and hepatitis
 - Appropriate laboratory tests to include CBC, direct screen and a CMP
 - Obtain patient's consent and authorizations to obtain patient's prior medical records

Behavioral Health in RHCs – SUD Treatment Documentation (Continued)

- Documentation from treating physician regarding the review of patient's prior medical records and the treating physician's evaluation and treatment of the patient based upon those findings
 - If unable to obtain prior records, physician must document efforts in the patient's chart
- Documentation regarding obtaining and reviewing KASPER Report once every three months
 - Document any abnormal findings and discussions with patient
- Written explanation of treatment alternatives and risks involved with SUD treatment
- Obtain written Informed Consent from patient
- If patient is female of child bearing age and ability
 - Documentation of pregnancy tests and results
 - Documentation of counseling as to risk
 - Documentation verifying that patient is not currently breastfeeding

Behavioral Health in RHCs – SUD Treatment Documentation (Continued)

- Document all in-office observations and/or presence of opioid withdrawal
- Document if patient is transferred from another treatment provider and has previously experienced withdrawal without a relapse
- Documentation regarding education to the patient about precipitated withdrawal

Behavioral Health in RHCs- Confidentiality of SUD Treatment Records

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Behavioral Health in RHCs – SUD Treatment Confidentiality and Part 2

- Patient confidentiality regulations concerning substance use disorder (“SUD”) are codified in the regs at 42 C.F.R. Part 2 (“Part 2”)
- Applies to programs who are: (1) federally-assisted and (2) hold themselves out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment
 - Federally assisted means: is licensed/certified/registered by the federal government, receives federal funds in any form, or is tax-exempt.

Behavioral Health in RHCs – SUD Treatment Confidentiality and Part 2

- Prohibits disclosures of information (directly or indirectly) that identify a patient as having been diagnosed, treated, or referred for treatment of a SUD
 - Disclosures even apply when the person seeking patient information: already has it, has other ways to get it, has a subpoena/warrant (unless accompanied by a court order), or is authorized by state law
- There are only limited circumstances where patient information may be disclosed without patient consent. These confidentiality regulations are more stringent than HIPAA

Behavioral Health in RHCs – SUD Treatment Confidentiality and Part 2

- Part 2 differs from HIPAA:

Purpose of Disclosure	HIPAA Exception?	Part 2 Exception?
Emergency treatment	Yes	Yes
Non-emergency treatment	Yes	No
Payment	Yes	No
Health care operations (quality improvement, care management, etc.)	Yes, to other covered entities	No, only to qualified service organizations (outside services such as billing or legal help, provided there is an agreement in place)
Research	Yes, under certain conditions	Yes, under certain conditions
Subpoena	Yes, if patient notice or protective order	No. Requires court order

Behavioral Health in RHCs – SUD Treatment Confidentiality and Part 2

- Consent to disclose Part 2 information to different recipients for different purposes can be made on a single form, but that form must:
 1. Follow regulatory requirements of valid written consent, and
 2. Include a written prohibition on re-disclosure

Behavioral Health in RHCs – SUD Treatment Confidentiality and Part 2

- Elements of valid written consent under Part 2:
 - Specific name or general designation of the program or person permitted to make the disclosure
 - Name or title of individual or the name of the organization to which disclosure is to be made
 - Name of patient
 - Purpose of disclosure
 - How much and what kind of information is to be disclosed
 - Dated signature of patient or personal representative
 - Statement that consent is subject to revocation except to the extent already relied on
 - The date, event, or condition upon which the consent will expire

Behavioral Health in RHCs – SUD Treatment Confidentiality and Part 2

- Disclosures must come with a warning:

“This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.”

Behavioral Health in RHCs – SUD Treatment Confidentiality and Part 2

Key Takeaways:

- Purpose of Part 2: encourage treatment by protecting patients from the stigma attached with substance use disorders
- Applicability to providers:
 - If a patient sees a *primary care physician* for SUD treatment, those records might not be covered by Part 2, depending on if that physician is “federally assisted”
 - If a patient sees a *specialist* for SUD treatment, those records ARE covered
- Permissible disclosures: almost always requires informed consent
 - Informed consent: A patient’s informed consent must be thorough enough to allow a continuum of care between the SUD providers and primary care in the RHC
 - Remember, even uploading electronically is a disclosure and impermissible without patient consent

Telehealth/Telemedicine

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[Why telemedicine?]



Even though 20% of the American population lives in rural areas, only 11% of all physicians practice there.

Source: Meeting the Primary Care Needs of Rural America: Examining the Role of Non-Physician Providers, National Conference of State Legislatures, <http://www.ncsl.org/research/health/meeting-the-primary-care-needs-of-rural-america.aspx>.

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Telehealth in Kentucky

- Telehealth is ever-expanding in acceptance as a way to combat some of the challenges presented by the “four A’s”
- It provides for greater accessibility and affordability while combating a lack of availability

Telehealth in Kentucky



- Kentucky's Medical Practice Act defines **telehealth** as "the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education." KRS 311.550(17).
- In 2014, the Kentucky Board of Medical Licensure ("KBML") adopted a helpful policy that accepts the Federation of State Medical Boards' model policy as the accepted and prevailing standard of practice for use of telehealth tools when practicing medicine.

Telehealth in Kentucky

- The KBML recognizes that a patient/physician relationship via telehealth can be established with the informed consent of the patient, but includes complicated requirements for:
 - Establishing the patient/physician relationship
 - Obtaining informed consent
 - Providing examination and treatment services
 - Keeping medical records
 - Maintaining patient privacy
 - Prescribing

Getting Reimbursed for Telehealth Services - MEDICAID

- Kentucky DOES cover mental health services under Medicaid under certain circumstances:

907 KAR 3:170 – Telehealth Consultation Coverage and Reimbursement

- Telehealth provider must be an approved member of the Kentucky Telehealth Network
- Requires use of two-way interactive video
- Requires a referral by a healthcare provider

Getting Reimbursed for Telehealth Services - MEDICAID

- For FQHCs and RHCs, a “visit” is defined as occurring either in-person or via telehealth, per 907 KAR 1:055
- Who may receive payment?
 - Psychiatrists
 - Licensed clinical social workers
 - Psychologists
 - Licensed professional clinical counselors
 - Licensed marriage and family therapists

Getting Reimbursed for Telehealth Services - MEDICAID

- Kentucky has a new pilot program for Remote Patient Monitoring (“RPM”)
- Not later than July 1, 2012 the Department must establish a pilot project which creates coverage provision and reimbursement criteria for telemonitoring services

Getting Reimbursed for Telehealth Services - MEDICARE

CMS announced final requirements for Medicare telehealth services in 2014.

- What are the requirements?
 - Beneficiary must be located in an area outside a metropolitan statistical area or in a Rural Health Professional Shortage Area (“HPSA”).
 - Medicare will only pay for face-to-face, interactive consultation service.
 - The patient must be present in an approved healthcare facility (hospitals, rural health clinics, physician offices, etc.)
 - An interactive audio and video telecommunications system that permits real-time communication between the provider and the beneficiary must be used.

Getting Reimbursed for Telehealth Services - MEDICARE

- Who may receive payment?
 - Physicians
 - Physician assistants
 - Nurse practitioners
 - Nurse-midwives
 - Clinical nurse specialists
 - Clinical psychologists
 - Clinical social workers
 - Dietitians or nutrition professionals



Getting Reimbursed for Telehealth Services - MEDICARE

- What services are covered?
 - Psychiatric and behavioral services
 - Remote medical services
 - Psychological testing
 - Psychotherapy
 - Prolonged office visits
 - Annual wellness check-ups
 - Non face-to-face chronic care management
 - Transitional care management services
 - Smoking cessation
 - Telehealth pharmacologic management
 - And more...



Reimbursement and Payment Issues for Telehealth

- Third party payers have not traditionally covered telehealth services in the same manner as other services, and not to the same degree as the federal government.
 - Telehealth services have been denied for coverage on the basis of being considered experimental or investigational.
 - Third party payers have been concerned that telehealth services will lead to overutilization.
 - Increased coverage costs are a concern as well, as increased access may lead to expanded coverage.
- **HOWEVER**, KRS 304.17A-138 prohibits the exclusion of telehealth services from coverage solely because they are provided via telehealth

[BHSOs]

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Behavioral Health Service Organizations (“BHSOs”) and other Provider Types

- Provider type licensed under 902 KAR 20:430
- These relatively new provider types may bill federal healthcare programs such as Medicare and Medicaid
- BHSOs may provide a comprehensive or mental health and substance use disorder services in a non-hospital outpatient setting
- Kentucky Medicaid also now recognizes a group practice of licensed therapists as providers
- Behavioral Health Multi-Specialty Groups (“MSGs”) do not need to be licensed by the OIG to participate in Medicaid – these providers must be an entity like an LLC or PSC and require at least one included provider to be previously enrolled in Medicaid

BHSOs – Covered Services

Medicaid-covered BHSO services include:

- Screenings
- Assessments
- Service planning
- Screening, brief intervention, and referral to treatment (SBIRT)
- Crisis intervention
- Mobile crisis services
- Intensive outpatient program services
- Psychological testing
- Day treatment
- Residential services for substance use disorders
- Peer support (provided by peer support specialists under supervision)
- Individual outpatient therapy
- Group outpatient therapy
- Collateral outpatient therapy
- Family outpatient therapy
- Assertive community treatment
- Comprehensive community support services
- Therapeutic rehabilitation program services
- Targeted Case Management

Any questions?



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