

Resource Document on Across State Line Psychiatric Consultation Considerations: Addendum to Risk Management and Liability Issues in Integrated Care Models

Approved by the Joint Reference Committee, June 2019

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Background

In 2013, an APA Resource Document on "Risk Management and Liability Issues in Integrated Care Models" was developed.¹ This document outlined liability issues in a new and emerging area of collaborative /integrated care. In this model psychiatrists' expertise is leveraged through curbside consultations and caseload reviews to provide more effective care for mild to moderate behavioral health conditions in the primary care setting. With the advent of CPT codes for the Collaborative Care Model, there has been a noticeable increase in the number of requests psychiatrists are receiving to do indirect consultations, caseload reviews, and education in states where they are not licensed. Further, the use of telecommunication solutions to enhance and expand existing services in one state can lead to increases in requests for psychiatric consultation to address patient choice, peer consultation, and workforce shortages in another state. States are actively developing policies to address the issue of licensure requirements for these consultation services, including physician to physician (P2P) consultation

¹ Bland, D.A., Lambert, K., Raney, L. APA Resource Document, "Risk Management and Liability in Integrated Care Models," *Am J Psych* 171:5, May 2014.

exemptions, reciprocity for bordering states, licensure compacts, and conditional licensure to name a few.²

This addendum to the Resource Document includes a discussion of some of the most common emerging psychiatric consultation modalities such as remotely providing consultant psychiatric provider tasks for Collaborative Care, eConsult, Project ECHO®, tele-teaming, mHealth and telehubs.

There is more limited discussion of telepsychiatry, which involves direct consultation with patients, since the rules around this are much clearer in terms of the necessity of having a license in the state where the patient is located. That said, some telepsychiatry companies and primary care clinics have begun to utilize “tele-teaming” to stretch limited financial resources and get psychiatric consultation for patients without necessarily seeing them in person. With all these variations and different models, it may be confusing, and, as a result, the Committee on Integrated Care decided that an addendum/update to the original Resource Document was needed to expand upon earlier concepts and provide more updated information based on the newer approaches to consultation.

There is no true road map and every state, court, judge and jury may determine liability differently. In the APA providing this document, the aim is to provide some guidance given these new and emerging issues, but it is not intended and should be interpreted as legal advice. There are a variety of models which may change liability risk considerably. In addition, there are wide variations in statutory language among states and federally.

Psychiatrists should consult state medical boards in the various states where they are providing consultation and/or consult with an attorney to ensure they are appropriately informed of applicable state laws and regulations. Also, seeking guidance from a risk management professional to discuss potential liability risks is warranted. In addition, since these approaches are new, sharing this updated Resource Document Addendum with a liability carrier may be helpful in providing more current information and education based on the newer consultation approaches. Resolving the issues of liability for cross-state consultation is important in leveraging psychiatric expertise to help address not only the psychiatric shortage but also the geographic maldistribution of psychiatrists and will enable the more efficient use of the existing workforce.

Considerations

Licensure for Out-of-State Consultation and the Physician-to-Physician (P2P) Exception

Most states have out-of-state consultation exceptions for an out-of-state physician to provide consultation to a physician licensed in another state. These exceptions typically do not include direct patient care. Some states have both special telemedicine licenses and consultation exceptions. Language and requirements differ considerably, and it is important to be aware of your state’s

² American Telemedicine Association 50 State Telemedicine Gap Analysis Report 2017
<http://www.americantelemed.org/policy-page/state-telemedicine-gaps-reports>

requirements and requirements in the state where you plan to provide services prior to engaging in out-of-state consultations. For example, states may have language such as consultations may occur on an “infrequent” basis or “occasional” basis whereas others may have specific frequency amounts.³ The language can be difficult to interpret, and it is important to obtain advice should you have questions.

Doctor-Patient Relationship

Most states have regulations on what constitutes a doctor-patient relationship. It is important to be aware of the language in your state since within this model there may be considerable “grey zone” differences such as whether a doctor-patient relationship is established if

- a physician views protected health information (PHI) or “de-identified” patient information,
- has access to the electronic medical record (EMR),
- receives payment for the psychiatric consultation and
- documenting the recommendations, which may or may not get included in the record, and
- whether the consultation was provided primarily as an educational resource to the primary care provider.

Advances in Reimbursement for Consultation

CPT codes for telephone or internet consultations (99446-99449 and 99451) between PCPs and professionals are reimbursed by Medicare as of January 1, 2019. These codes could be used for curbside consultation and eConsult for example. The CPT codes for the Collaborative Care Model (99492-99494) include the psychiatric consultant’s time within the Relative Value Units (RVU) established when CMS activated the code. This indicates there is planned and expected reimbursement for the consultations, which do not involve direct patient evaluation.

Purpose: Primarily Education or Patient Care

Some models have primarily an educational purpose. Others are more directed at individual patient care but may have the potential to take advantage of “case-based learning” and have elements of education added to the consultation. Still others have a blended model with specific case-consultation occurring in the context of training.

Forms of Cross-State Consultation

The following is a discussion of several of the predominant models being utilized for psychiatric consultation across state lines. It includes their similarities and differences and how these might change liability and the need for the consultant to be licensed in the state where she/he is providing the consultation.

³ Realizing the Promise of Telehealth: Understanding the Legal and Regulatory Challenges citing Center for Connected Health Policy, American Hospital Association, May 2015; Telemedicine Gap Analysis Report 2017 <http://www.americantelemed.org/policy-page/state-telemedicine-gaps-reports> Matrix page 75 - 80

Remote Collaborative Care

CPT codes for reimbursement for the Collaborative Care Model are now available (99492, 99493, 99494) and the use of them is spreading as state Medicaid agencies begin to adopt them in addition to Medicare, Tricare, and some commercial insurers. The code is billed under the primary care physician's (PCP's) NPI number and they receive the reimbursement. A key task in billing the codes requires a psychiatric consultant to provide a weekly caseload review of the patient registry, with each patient having documentation of at least one review in a given month of billing the codes. This requirement limits the use of these codes in areas where there is a lack of psychiatric providers, and the opportunity exists for psychiatrists in one state to provide the registry review in another. Remote review typically consists of the psychiatric consultant on the phone with the behavioral care manager while having the registry available for both to view onscreen. Patients in the registry are reviewed and the psychiatric consultant makes recommendations for adjusting the care of patients who are not improving. It is also quite common, and extremely useful, for the psychiatric consultant to have at a minimum view-only access to the patient's EMR. Greater access allows the recommendations to be typed directly into the EMR and sent to the PCP through a "tasking" mechanism. Of course, there is extensive exposure to PHI in this process.

Disclaimer from AIMS/APA Support and Alignment Psychiatrist curriculum

"The above treatment considerations and suggestions are based on consultations with the patient's care manager and a review of information available in the Mental Health Integrated Tracking System (MHITS). I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to call me with any questions about the care of this patient."

- Dr. X, Psychiatric Consultant
- Phone #
- Pager #
- E-mail

eConsult

Electronic consultation (eConsult) is a mechanism for providing timely consultation to busy PCPs who are seeking help managing a patient without having to refer for an in-person consultation. eConsult utilizes a secure electronic platform to obtain asynchronous consultative advice, typically within 24/48 hours. With the patient's consent, the PCP initiates the eConsult request by providing the consultant with specific, identified patient information using a brief eConsult template. Records including recent progress notes, labs, x-rays, etc can be attached by the PCP to the eConsult request. The psychiatric consultant may send back educational or other information to the PCP while answering the specific question. The consultant receiving the request may have additional access to the patient's medical record or may rely solely on the clinical information provided by the PCP. The eConsult request and the consultant's response may become part of the patient's medical record. There is no direct contact between the patient and the consultant and this model is designed for a one-time consultation to the PCP. eConsult is being provided across state lines and across the country by various technology companies. eConsults may or may not be seen as direct patient care, dependent upon a variety of

factors including the level of patient information reviewed and the local medical board’s interpretation and regulations.

Payment for eConsults has been limited and has typically been provided in large health care organizations as part of their support to their primary care clinics. It has been shown to reduce costly specialist referrals and more interest is there to provide reimbursement through Medicaid and other providers, particularly in value-based payment arrangements. With the recent decision regarding uncoupling the telephone and internet consultation codes from the Medicare telehealth restrictions, there is now more interest in using these to reimburse for eConsult.

Below is one eConsult company’s language used to explain the relationship between the consultant and the PCP. Remember this is the company’s explanation and it would ultimately be up to the courts to decide if liability in the event of a claim.

“the Platform is provided for educational purposes only and is not a substitution for diagnosis, treatment, prescription or supervision by a specialist physician. If you are a PCP, you acknowledge and agree we are not a health care provider and that the opinions provided by the Consultants are not diagnosis, treatment, prescriptions or supervision of any kind. Information provided through the Platform is not a substitute for treatment by a physician or healthcare provider, and you agree you will not rely on the information provided by the Consultants in directing patient care. Consultants may provide their informal thoughts regarding patient care in response to questions asked....” Rubicon MD, Terms of Service dated July 25, 2017

Project ECHO

Project ECHO (Extension for Community Healthcare Outcomes) is a community provider focused, hub and spoke, tele-mentoring, tele-consultation, and tele-education model. Originally developed at the University of New Mexico (UNM) to support primary care providers in hepatitis C management, the ECHO model strives to improve access to complex chronic disease and specialty care in underserved communities.

Project ECHO involves a multidisciplinary team of content experts (“hub”), who tele-mentor primary care teams (“spoke”) in the care of specific conditions via videoconferencing on a regular and recurring basis. It is grounded in case-based consultative learning and formal didactic education. The aim of the model is to increase the capacity of primary care teams to treat these specialty conditions within their own practices. Over the last decade, this model has expanded across the world and encompasses numerous condition-content areas, including psychiatric care. Unlike typical teleconsultation modalities, in which a single psychiatrist consults with a single PCP, psychiatric focused ECHO programs connect a hub of multiple behavioral health specialists with spokes of multiple primary care teams simultaneously, allowing for shared, interdisciplinary case-based learning.⁴ A teleECHO clinic can be provided both within the same state and across state lines.

⁴ Hager, B., Hasselberg, M.J., Arzubi, E., Betlinski, J., Duncan, M., Richman, J., & Raney L. (2018). “Leveraging behavioral health expertise: Practices, potentials, and policy implications of the Project

Within a teleECHO clinic, following a brief didactic session, the primary care team presents to the hub psychiatry team a few select patients using de-identified health information. There is no direct involvement between the psychiatry team and the patient. Following the consultation, a written document is provided by the hub specialists to the primary care team with case recommendations and suggestions for diagnostic assessment and treatment for the patient discussed. These consultations typically include the disclaimer language in the box below.

The majority of these teams are grant funded and generally there is no fee for service billing. However, with the signing of the ECHO Act into law in December 2016, federal policymakers have called for the examination of the ECHO model to improve programs of the Department of Health and Human Services, driving insurer discussions around payment innovation to sustain this model.⁵ Depending on the location, there have been some examples where the ECHO model has been integrated into value-based reimbursement products within accountable care organizations or where third party payments have occurred which, may change the nature of Project ECHO, especially if patient identifiers are necessary for billing.

Typical ECHO model disclaimer language:

“Please note that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any UNMHSC clinician and any patient whose case is being presented in a Project ECHO setting.”

Tele-teaming

The concept of “tele-teaming” has evolved from practices using telepsychiatry over the past decade. There has been noticeable evolution where some telepsychiatry services (especially in the context of primary care/integrated behavioral health care services) have utilized a virtual psychiatrist as part of team-based models of care. Roles in this model typically include care collaboration and supervision of other teammates (psychologists, social workers, counselors)⁶, physician to physician consults, and consults with other providers, as well as direct patient care if needed. Psychiatrists often provide consultation thru teammates without necessarily seeing a patient directly. In addition to this model being used in the primary care setting (e.g. integrated care) this has also been deployed in other outpatient, inpatient, and substance use treatment settings. Tele-teaming can occur within a single state or across state lines.

ECHO® approach to primary care and behavioral health integration in rural and underserved areas,”
Psychiatric Services, 69(4), 366-369.

⁵ ECHO Act, Pub L No. 114-270, 130 Stat 1395. 2016.

⁶ Shore, Jay; ‘Doc in a box’ vs. ‘tele-teaming’: Contending models of telepsychiatric care. Clinical Psychiatry News, October 25, 2016

Tele-hubs

All-inclusive behavioral health “tele-hubs” could include any combination of the above approaches and provide an a la carte menu of telehealth solutions within a state, across state lines (and to many states simultaneously) as well internationally.⁷ The intent is to provide a variety of solutions under one organizational hub. The individual licensure and liability concerns of each modality in the hub would have to be considered given they may provide out of state and international consultation.

mHealth

mHealth offers the potential of increasing access to care by providing care services, or augmenting care services, through the use of applications (apps) installed on mobile devices like smartphones. While the potential of mHealth is significant given the high prevalence of smartphone ownership, thus far there is only nascent evidence on the efficacy, clinical validity, or cost effectiveness of mHealth approaches.⁸ In the context of this report, the most common use of mHealth is actually telepsychiatry where a patient is connected to a physician or therapist via a smartphone app. Thus, many considerations around this type of care are not unique to mHealth and would likely fall under other appropriate categories as detailed elsewhere in this document.

However, mHealth does offer some unique features such as remote monitoring that can be done via surveys (active data) and sensors like a GPS (passive data). However, the use of these types of mobile data and any corresponding evidence with respect to efficacy and patient outcomes, remains more in the research realm than the clinical domain at this time. But given the rapid progress in mHealth research, issues regarding cross-state transfer of patient data from devices will soon become a topic requiring further consideration. One issue of concern today is that many mHealth apps are advertised as offering clinical services but, in their privacy policies, claim rather to be health and wellness devices. Health and wellness devices are not currently under the purview of the FDA or (usually) HIPAA and are not subject to any medical oversight or regulation. Thus, privacy protections or clinical standards that clinicians and patients may expect from digital services claiming to offer mental health services may be lacking. Keep in mind that clinicians are obligated to maintain privacy for their patients, and it is important to determine whether the apps are HIPAA compliant. It is important to carefully examine the details of the privacy policy of mHealth apps and devices to discern where a patient’s data is sent and with whom it may be shared. If the app is not claiming to fall under medical regulation, it is likely that patient data is not only crossing state lines but could also be sent internationally.⁹

Sample disclaimer language:

⁷ Raney, Bergman, Torous, Hasselberg; Digitally integrated primary care and behavioral health: how technology can expand access to effective treatment. *Current Psychiatry* 2017

⁸ Safavi K, Mathews SC, Bates DW, Dorsey ER, Cohen AB. Top-Funded Digital Health Companies And Their Impact On High-Burden, High-Cost Conditions. *Health Affairs*. 2019 Jan 1;38(1):115-23.

⁹ Wisniewski H, Liu G, Henson P, *et al* Understanding the quality, effectiveness and attributes of top-rated smartphone health apps *Evidence-Based Mental Health* Published Online First: 11 January 2019. doi: 10.1136/ebmental-2018-300069

Headspace is a provider of online and mobile meditation content in the health & wellness space. We are not a health care or medical device provider, nor should our Products be considered medical advice. Only your physician or other health care provider can do that. While there is third party evidence from research that meditation can assist in the prevention and recovery process for a wide array of conditions as well as in improving some performance and relationship issues, Headspace makes no claims, representations or guarantees that the Products provide a therapeutic benefit.¹⁰

Cross-State Consultations Overview

There are many models of care that may be affected by legal questions surrounding cross-state consultations. Only a few are highlighted in this document, and thus it should not be considered to be comprehensive or definitive. Similar to issues outlined in the APA Resource Document on “Risk Management and Liability Issues in Integrated Care Models,” these are new and emerging areas. Some of these models provide cross-state consultation with peer- to -peer consultation whereas others provide direct patient care across state lines. It is important for clinicians to be aware of their obligations and licensure requirements prior to engaging in any cross-state consultation services. Consulting with an attorney or risk management professional is advised if questions arise.

State Rules/Regulations

This is an evolving area, and it is important that psychiatrists are up to date and aware of requirements/obligations if you are engaging in cross-state consultation or telemedicine across state lines. As of the time of this publication, we note that there are a number of states that offer special licenses for telemedicine and/or provide unique exceptions to licensure for the purposes of cross-state consultations by physicians. Currently, there are ten state medical boards that offer special licenses or certificates that permit doctors to treat patients located in other states via telemedicine.¹¹

Most states have cross-state consultation exceptions for an out-of-state physician to provide consultation to a physician licensed in that state. These exceptions typically do not include patient care. Some states have both special telemedicine licenses and also have consultation exceptions. However, it is important to know the specific language before engaging in this kind of consultation to determine if you are able to take advantage of these exceptions and licenses. There are some states that have specific requirements to be licensed in the state where consultation/telemedicine occurs. Further, it is important to know the specific language within the state regulation to determine how a consultation is defined and who it can involve (patient or other provider).

States may also have statutory language regarding frequency of cross-state consultations. These may be on an “infrequent” or on an “occasional” basis and may also have specific amounts of what this means within the statutory language. A few examples: Delaware limits the number of consultations by

¹⁰ <https://www.headspace.com/terms-and-conditions>

¹¹ *Realizing the Promise of Telehealth: Understanding the Legal and Regulatory Challenges* citing Center for Connected Health Policy, American Hospital Association, May 2015.

an out-of-state physician to 12 per year, whereas Iowa stipulates no more than 10 consecutive days of consultations and no more than 20 per year.¹²

Liability and Risk Management Considerations

Since there are a variety of models and the role of the psychiatrist may vary, liability or risk management considerations vary considerably. It is recommended that you obtain advice from an attorney or risk management professional should you have questions about liability risk. However, there are some general principles that are important to consider. They are as follows:

- **Regulations.** Each state has its own set of laws/ regulations. Ensure that you are aware of the regulations within the state where the patient is located on such issues as civil commitment, duty to warn, or child endangerment. It is also important that your office have adequate policies and procedures that are compliant with state and federal law.
- **Privacy.** HIPAA regulations must be observed, as well as any additional state regulations for privacy, confidentiality, and patient rights. Ensure the system you are using is HIPAA compliant.
- **Security.** Network and software security protocols to protect privacy and confidentiality should be in place, as well as appropriate user accessibility and authentication protocols. Measures to safeguard data against intentional and unintentional disclosure should be in place for both storage and transmission.
- **Safety.** Consider whether indirect consultation is appropriate for the patient. Ensure that there are emergency plans in place in the state where the patient is located should the patient need assistance.
- **Informed consent.** Informed consent for indirect consultation is typically not required. However, the requesting physician may inform the patient, and should document the request and recommendations in the patient's chart.
- **Documentation.** Documentation may differ depending on the type of the services provided. Some models may not have documentation since there is no PHI exchanged, while others do have this available.
- **Contracts.** Depending on the program and the provider, there may be a contract, or a memorandum of understanding entered into. It is important that a participating provider (whether PHI is reviewed or not) is aware of obligations and whether there is a contract for services prior to beginning. It is important that a contract is reviewed by attorneys for all parties involved to determine obligations, ensure clarity, and determine whether there is

¹² *Id.*

potential for liability risks. It is important when serving in this capacity that a contract incorporate language about your role and responsibilities.

- ***Psychiatrist's Role.*** Your role should be identified with the referring provider. Know whether you are providing a true consultation and what your responsibilities are.
- ***Informal Inquiry/Consultation.*** Be cautious when an informal inquiry turns into patient diagnosis and treatment. This may change your role/duties to the patient.