

Telepsychiatry and Medical Insurance: Comparative Perspectives Between India and the United States

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ABSTRACT

Telepsychiatry is a cost-effective alternative to in-person psychiatric consultations. The COVID-19 pandemic brought about a sharp spike in the utilization of telepsychiatry due to ongoing restrictions on gatherings and traveling. In recognition of the importance of telemedicine in general, and telepsychiatry specifically, telemedicine practice guidelines and telepsychiatry operational guidelines have been released. Due to the rising trend in telemedicine, the Insurance Regulatory and Development Authority of India (IRDA) incorporated teleconsultation health insurance coverage at a level on par with regular in-person consultations. In contrast, in the United States of America, private insurance coverage for telepsychiatry has been in vogue for some time. In this paper we draw comparisons between India and the United States on telepsychiatry and health insurance. We compare the evolving regulatory policies of these two countries in relation to existing insurances plans that are available, the challenges in implementation of new regulations and the possible ways to overcome the challenges to make telepsychiatry affordable to all.

Keywords: Telepsychiatry, insurance, India, US, Medicaid, Medicare, IRDAI

Telemedicine is defined in the broadest sense as “interactive audio, video, or data communication for clinical care provision, provided in place of in-person treatment.”¹ Telepsychiatry is a branch of telemedicine that allows clients with barriers to in-person visits to interact with mental health professionals using the telephone or video-conferencing devices. The primary “physical” examination for psychiatric assessment is the mental status examination, which relies on interactive com-

munication to assess emotional state and cognitive functions—this makes psychiatric care adapt well to the use of electronic interfaces. The social-distancing recommendations accompanying the ongoing COVID-19 pandemic have led to an increased demand for psychiatric care provision through telepsychiatry in India and the United States (US).² In this article, we compare the medical insurance systems in India and the US with a focus on telepsychiatry and contrast the way the two systems have been able to respond to the recent increased demand for these services.

Health Insurance in India

Health insurance provides payment to health care providers for the cost of a patient’s medical treatment, as specified by the insurance plan in which the patient is enrolled. In India, health insurance is broadly categorized into private and public health insurance. Public insurance is provided by the government to the economically poorer sectors and selected vulnerable populations, such as individuals with disabilities. Public health insurance is financed by state and central government funds. A few schemes require insurers to pay a nominal sum as premiums. In contrast, private insurances operate by charging periodic premiums that the insured regularly pays to have ongoing health insurance coverage. There are more than 20 companies that offer private health insurance. Public sector government-owned health insurance companies also provide health insurance coverage by charging premiums similar to private operators: there are about four such companies (Table 1). Government health insurance (and assurance)

schemes include Employment State Insurance (ESI), Rashtriya Swasthya Bima Yojana (RSBY), Central Government Health Scheme (CGHS), and Ayushman Bharat. Most insurance plans provide coverage for acute or prolonged inpatient care and day-care (ambulatory) procedures. Outpatient medical care is not covered by most public or private insurance companies barring a few exceptions, such as Swavlamban and Niramaya scheme (public) and Star Health Insurance (private insurer).

Based on how payments are processed, a health insurance claim is of two types: The first method is via cashless processing, where bills for services are directly submitted to the insurance agency (third-party payer) by the affiliated hospital. The other method requires the upfront payment of the treatment costs by the patient, who can later file for reimbursement from the insurance agency. Insurance Regulatory and Development Authority of India (IRDAI), a regulatory body that monitors and regulates the functioning of the insurance companies: both public sector and private sector insurance companies (for both health

TABLE 1.

List of Public Sector Health Insurance Companies Owned by the Government

SI No	Public Sector Health Insurance Companies in India
1	The New India Assurance Co. Ltd
2	United Insurance Company
3	National Insurance Co. Ltd
4	Oriental Insurance

and other general insurance matters). Mental illnesses recently got included in the ambit of health insurance under the directions IRDAI quoting the Mental Health Care Act (MHCA) 2017 (Section 21). Nevertheless, complete mental health coverage is still not embraced by most insurance companies.³ Preexisting mental illnesses are covered by Niramaya and Swavlamban insurance schemes (which are government health insurance schemes)⁴ and by few private insurance companies (for higher premiums).⁵

Insurance Coverage for Psychiatric and Telepsychiatry Services in India

The MHCA 2017 is a milestone in the history of psychiatric care in India and a laudable step toward improving care for persons with mental illness. Section 21 of the MHCA 2017 mandates that every health insurance provider should provide equitable coverage for mental illnesses similar to physical illnesses. This provision in the MHCA 2017 legislation is similar to the Mental Health Parity and Addiction Equity Act introduced in 2008 in the US. Due to the chronic nature of many psychiatric conditions, the limitation on insurance coverage of outpatient services in India is likely to become a limitation to access telepsychiatry consultation. Many clients who have private health insurance are unaware of the option to purchase add-on outpatient services, most likely due to inadequate information provided by the insurance agents, thereby increasing the health expenditure for that individual. Ayushman Bharat, arguably the largest health assurance scheme in the world, does not provide coverage for outpatient consultation, thereby creating a challenge to patients with psychiatric disorders, who generally require continued outpatient care for the long term.

Severe restrictions on travel in India, brought by the COVID-19 outbreak has accelerated the adoption of telecommunication usage into the health sector, and telemedicine has become a considerable boon to health care providers and consumers.⁶ Telecommunication-based health services were operational in India even before the COVID-19 pandemic,

albeit with no legal framework to provide oversight.⁷ The COVID-19 crisis has played a pivotal role in highlighting the benefits of telecommunication-based health services, which has led to the establishment of Telemedicine Practice Guidelines (TPG) on Mar 25, 2020, by the Medical Council of India. TPG provides the legal and regulatory framework for telemedicine practice in India.⁸ Soon after TPG, Telepsychiatry Operational Guidelines (TOG) were formulated specifically for psychiatric practice.⁹ Subsequently, IRDAI issued a notification to insurance companies to provide insurance coverage for the teleconsultations on par with in-person consultations.¹⁰ It is praiseworthy that IRDAI took such action within two months of the establishment of TPG. IRDAI ascertains that such claims should be in line with the “terms and conditions” in the insurance policy contract issued to the client at the time of premium payment. It may be noted however that only a handful of companies offer outpatient service coverage⁵ usually as an add-on; therefore, all policies may not provide coverage for telepsychiatry services, which would essentially count as outpatient health service.

India: Overcoming Challenges with Insurance Coverage for Telepsychiatry Highlighted by the COVID-19 Pandemic

The TPG and TOG allow a psychiatrist to opt for teleconsultation whenever in-person consultation is not possible, or the client and the psychiatrist agrees to choose the “tele” mode of consultation. These guidelines also give an outline of safe and secure methods to maintain medical records of teleconsultations. Financial reimbursements for psychiatric teleconsultation services are not yet standardized in India. Analogous to in-person visits, teleconsultations incur a fee. In India, the teleconsultation fee can be paid either out-of-pocket by the patient or through insurance coverage (which requires more clarity as of now). The lack of standardization of payment coverage for teleconsultations can lead to huge bills for patients.

With regard to public insurance schemes, only a couple of them have provisions for covering outpatient consultations (Swavlamban and Niramaya scheme).^{4,11} The flagship Pradhan Mantri Jan Arogya Yojana (PMJAY) under the Ayushman Bharat scheme does not cover Out-patient (OP) consultations,¹² excluding the brief prehospitization (2 days) and the posthospital (15 days) periods during which it is covered. Understandably this would not come to the benefit of many patients in psychiatry who will require continued follow-up care on an OP basis.

Central Government Health Scheme (CGHS), a health assurance scheme, provides benefits to all present and former Central Government employees. CGHS covers both outpatient as well as inpatient expenses. Recently, in view of the COVID 19 pandemic, the CGHS scheme has enabled teleconsultations for its beneficiaries for certain specialties such as medicine, ENT, eye, orthopedics, but psychiatry was not included.¹³ Government schemes such as CGHS and PMJAY should expand coverage to include telemedicine and telepsychiatry service.

Health Insurance in the US

In the US, health insurance is broadly categorized into private and public health insurance (governmental programs). The Affordable Care Act (Obamacare) originated in March 2010 after it was passed by the US congress, establishing basic legal protections for health care: a near-universal guarantee of access to affordable health insurance coverage, from birth through retirement. By 2018, a major portion of the population under the age of 65 got insurance covered either by private health insurance through their employers (67.3%) or by the direct purchase of health insurance (12.2%). Public insurance through Medicare (17.9%) and Medicaid (16.5%) programs that came into existence in 1965 covers 34.4% of the US population.¹⁴ The Center for Medicare & Medicaid Services (CMS) provides administrative oversight over Medicare, Medicaid, and other Federal (central) health care programs, overseeing all regulatory and funding decisions.¹⁴ **Table 2** describes the salient features of Medicaid and Medicare.

The Medicare program is managed by CMS at the federal (central) level and resembles the government insurance program overseen or sponsored by the Central Government in India. Medicare is a uniform national health insurance program designed to cover individuals aged 65 or older, individuals younger than 65 with disabilities, and people of any age with end-stage renal disease. Medicare is primarily funded by taxes from working people to provide services to aged beneficiaries. Similar to government insurances in India, Medicare coverage primarily supports acute care like inpatient hospitalizations and emergency medical conditions. Medicare also supports long-term nursing home care and routine eye care; importantly, outpatient prescription drugs are not covered. Unlike India's public insurance, Medicare beneficiaries can purchase; Medicare-approved private supplemental health insurance to cover their prescription medications.¹⁵

Medicaid is a cooperative, jointly financed by federal and state health insurance programs for qualifying lower-income adults between ages 18 and 65, pregnant women, and children. It covers preventive, acute, and long-term care services. The federal share of total expenditures ranges from 50% to 83%, with the poorer states receiving a higher match from the Federal Government. In February 2020, 48 state Medicaid programs reimbursed some form of telepsychiatry services.¹⁶ Medicaid reimbursement varies across different states, with ten state Medicaid programs reimbursing fee-for-service for not only general, synchronous or live interactive audio-video conference, the most universally accepted format, but also Remote Patient Management and store-and-forward care provision. State Medicaid policies, rules, and laws are rapidly changing for telepsychiatry, especially since the beginning of the Covid-19 epidemic. The benefit of unprecedented parity for coverage of equivalent psychiatric services by telemedicine in many states is qualified by uncertainty about whether the current funding models will continue once the pandemic recedes.¹⁶

The majority of the US population is covered by private health insurance. Covered individuals are required to pay

a monthly premium for their insurance. State insurance commissioners in the US provide regulatory oversight for over more than 900 private health insurance companies. The federal government does not generally regulate private insurance companies. Minimal coordination occurs between private and public insurance programs; some people have both public and private insurances while others have neither. However, strategically, CMS generally leads the way in setting new policy, with the private insurance community often shifting their coverage strategy to mirror that of CMS.

In the private health insurance arena, The Health Maintenance Organization Act of 1973 established the foundation for managed care organizations (MCO) and their comprehensive cost-saving methods. An MCO is a health plan with a group of doctors and other providers working together to provide health services to its members in a manner organized to manage cost, utilization, and quality. MCO's differ from simple private insurers such as Blue Cross/Blue Shield by being vertically integrated systems that provide not only the insurance coverage to their clients but also the health and delivery system. Often businesses contract with these MCOs to provide health care coverage for their employees. The policy of each MCO dictates many aspects of health care. Provider networks influence how and where a patient receives their medical care. Utilization management, medication formularies, and provider incentives influence the health care delivery options the provider selects (**Table 3**).¹⁷ Coverage for psychiatry, addiction, and telepsychiatry services are determined by the individual MCO and can vary widely.

More recently, large health care systems, such as the Cleveland Clinic, have begun to provide their own health care insurance product to better access their facility for services.

As of 2018, approximately 8.5% (27.5 million) of the US population were uninsured at any point during the year. Nevertheless, persons in the US without health insurance are not devoid of health care options. Although uninsured patients receive fewer and less coordinated services than individuals with insurance, many uninsured patients re-

ceive health care services through public clinics and hospitals, state and county public health department programs, or private providers who finance the care through charity by shifting costs to other payers.^{18,19} Pharmacies often prescribe select medications for free or at a low cost.

Insurance Coverage for Psychiatric and Telepsychiatry Services in the US

The American Psychiatric Association (APA) formally endorses the use of telepsychiatry for the following psychiatric services: initial psychiatric assessment, medication management, individual, group, and family therapy; and psychoeducation. The APA bases this support on strong evidence that telepsychiatry results in improved patient outcomes and high client satisfaction surveys.²⁰ The broad reach of telepsychiatry in the US has enabled care providers to effectively administer evidence-based care to formerly inaccessible populations, including children and adolescents, nursing home populations, college students, veterans, rural residents, immigrants, and incarcerated individuals.²¹

Despite the success of telepsychiatry, state restrictions on Medicaid coverage (government-funded) insurance, by provider-type and credentialing status, and which limit coverage only to patients in approved rural setting sites, have constrained the use of this modality. Even as states gradually lift these restrictions and new laws mandate insurance parity between equivalent in-person and telemedicine visits, administrative approval by government insurance agencies lags.¹ However, the Covid-19 pandemic has serendipitously led to significant relaxing of these legal restrictions, thus facilitating new insurance models for telepsychiatry in the US.

The Affordable Care Act, with its goal of affordable access, allowed many insurance companies to embrace coverage for telemedicine services, even before the pandemic. States are increasingly passing parity laws mandating private insurance companies to provide coverage for telemedicine services.²² At the time of this writing, many states and

TABLE 2.

Medicare and Medicaid Descriptions

Insurance	Medicare	Medicaid
Governance	Federal health insurance program; strictly governed by federal government	Joint federal and state program; but governed by state governments
Eligibility criteria	(a) 65 years or older; (b) under 65 with certain disabilities; (c) any age and who have End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS)	Individuals and families with limited income and resources
Coverage includes	Inpatient care; skilled nursing facility (Part A); outpatient, and some preventive care (Part B), prescription drugs (Part D)	Inpatient care; skilled nursing facility, outpatient care in federally qualified health center, rural health clinic
Costs	Cost depends on the coverage	Cost depends on the individuals' income and the rules, policies, and procedures in the given state. Each state has their own Medicaid rules

TABLE 3.

Common Types of MCOs

Health Maintenance Organizations (HMOs): A patient chooses an in-network primary care provider, who is responsible for referrals to specialists. The insurance typically pays only in-network providers and is generally the cheapest option.

Preferred Provider Organizations (PPOs): Patients can choose from a list of in-network providers for primary and specialty care. Patients can also see out of network providers but will incur a higher cost than in-network counterparts. Additionally, patients can typically see in-network specialty providers without a referral. Prices tend to be higher due to increased flexibility.

Point of Service (POS) Organizations: Point of service organizations are a cross between HMO and PPOs, which require a PCP but allows patients to see in-network specialists without referrals. The cost is typically between HMO and PPOs.

Exclusive Provider Organizations (EPO): EPOs allow patients to choose their in-network providers without the need for establishing a primary care provider and receiving referrals. However, all out of network expenses are not covered.

private insurers provide not only parity of Psychiatry services between telepsychiatry and in-person visits but also parity of reimbursement levels within the standards and scope of usual practice. State laws regulating telepsychiatry practice and reimbursement vary widely across the US; hence, Mental Health Professionals desiring to practice telepsychiatry need to acquaint themselves with their states' laws governing insurance reimbursement for services, regulations concerning obtaining consent for treatment by telemedicine, and rules governing practicing across state lines. MCO are increasingly joining hands with companies that provide 24/7 access to care at a low cost by physicians who partner with these entities.²³ In essence, telepsychiatry could be an option to meet the growing demands for urgent psychiatric assessments.

Coverage for psychiatry, addiction, and telepsychiatry services are determined by the individual private insurer or MCO and can vary widely. Prior to scheduling a video/telephone consultation, patients typically check with their individual MCO insurance provider to determine if psychiatry services are approved, if the desired provider is in-network, and whether telepsychiatry services are covered. Some states have mandated that telepsychiatry services are reimbursed.²⁴

In view of the many benefits of telehealth, many states in the US are implementing policies promoting the utilization of telemedicine services. The American Telemedicine Association (ATA) has released its 2019 State of the States Report: "Coverage and Reimbursement," which describes policies and telehealth laws, allowable patient settings for telehealth, allowable technologies and insur-

ance provider types, reimbursement and coverage, across all states and District of Columbia (DC) in the US. Most states do not reimburse telehealth e-mails, phone calls, or fax communications.

Important conclusions of ATA report 2019²⁴ and Center for Connected Health Policy (CCHP) Spring 2020²⁵:

1. Since 2017, 40 states and the DC have functional policies on telehealth coverage and reimbursement. All 50 states and DC currently reimburse for some type of live video telehealth services. Reimbursements vary widely from state to state with regards to medical specialties covered.
2. A total of 36 states and DC have parity policies (equivalent coverage of in-person health services reimbursements and telehealth reimbursements) for private payer coverage
3. Medicaid payment parity policies exist in 28 states; 16 of them have mandated payment parity for private payers.
4. The majority of states recognize the benefits of remote patient monitoring (RPM) and store and forward (S&F); 16 state Medicaid programs reimburse for store-and-forward, and 23 states reimburse for remote patient monitoring.
5. The patient's residence is not eligible as the originating (patient-located) site. Nineteen states do allow the personal residence to be an originating site under certain rules.
6. Thirty-nine states and DC have a consent requirement in Medicaid policy, regulation, or the law. This usually includes either a verbal or written acknowledgment by the patient that their care will be provided—by telehealth in place of an in-person visit, an acknowledgment of (remote) risk of penetration of HIPAA protected platforms by hackers or malware, and agreement to participate in the visit in a HIPAA compliant private location.

US: Overcoming Challenges with Insurance Coverage for Telepsychiatry During the COVID-19 Pandemic²⁵

Telehealth policies during COVID-19 have been rapidly evolving. In the US, Medicaid providers now have broad

authority to utilize telehealth and telephonic consultations in place of face-to-face requirements. Special telemedicine licensure requirements were waived for all Medicaid providers, even though state-mandated requirements still apply. Policy changes in response to COVID-19 by private insurers (Aetna, Cigna, and Blue Cross Blue Shield) have made telehealth more widely available. Waivers of copays for telepsychiatry services have been offered for a period. The following are the key findings of the changes that the Center for Medicare and Medicaid Services has made to telehealth policies for fee-for-service care since March 2020:

1. There are no geographic restrictions for patients. The patient can participate in the telehealth interaction from their home. Some states make allowances for practitioners to see patients in neighboring or adjoining states. Twenty-nine states have adopted the federation of State Medical Boards Interstate Medical Licensure Compact, which allows for an expedited licensure process to obtain licenses to practice in the other states.
2. The practitioner can provide services when at home and need not put their home address on the insurance claim
3. Apart from live video, audio-only telephone services for behavioral health counseling and educational services are allowable.
4. All practitioners can bill Medicare for professional services provided.
5. The amount of reimbursement will be the same as if provided in-person. Some rates for telephone visits have increased to match in-person care by medical complexity rather than contain artificial ceilings on billing codes.
6. At the beginning of the pandemic, only a few states permitted audio-visual telehealth exams to qualify as originating the patient-provider relationship, which is required to write a prescription for a controlled substance. However, given concerns about the ongoing opioid epidemic, states and DEA laws were relaxed at the beginning of the COVID-19 pandemic, allowing for care provision for medication-assisted treatment (MAT) and the prescribing of other controlled medications following an interactive audiovisual interview.

Conclusion

The silver lining in the COVID-19 pandemic is the rapid expansion of telepsychiatry. But telepsychiatry practice might return to pre-COVID levels once the COVID-19 pandemic abates. Nevertheless, the data drawn from the many positive outcomes and the satisfaction reviews will help in asserting the value of telepsychiatry to key CMS, private insurance, and MCO stakeholders. Telepsychiatry will likely remain a permanent and prevalent practice form for the delivery of psychiatric services in the US.

India has also made strides but still struggles against numerous roadblocks. IRDAI has directed the insurers to allow telemedicine consultation claims. Telepsychiatry comes under the purview of TPG, yet barriers persist at the policy implementation and patient education levels. In the US, numerous changes in the insurance coverage have occurred to accommodate telemedicine during the COVID 19 pandemic. In India, there is a need for government solutions for more fair distribution and better education about benefits. Insurers, both the public sector and private companies, should reimburse more preventative services, which would include claims for both hospitalization and outpatient services, including telepsychiatry costs incurred. Many private companies offer supplemental benefits for outpatient services consultations, but we propose that these should be a mandatory part of all the insurance plans and rather than only available as a paid supplement. Decreasing psychiatric care costs would enable clients to afford preventative outpatient care, reducing noncompliance with medications due to nonaffordability, relapse of psychiatric conditions, hospitalizations, and secondary disability-adjusted life years (DALY) due to psychiatric illnesses. Government health insurance schemes also need to provide coverage for outpatient services so that the economically weaker populations can also get the benefit of telepsychiatry. Outpatient care and telepsychiatry lag behind acute care coverage in both India and the US, yet recent strides provide hope for continued expansion of these important services in both countries.

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The Relevance of Telemedicine in Continuing Medical Education

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ABSTRACT

Continuing medical education (CME) is essential for medical practitioners to update their knowledge and skills periodically to provide clinical care in keeping with the evidence available. Traditional methods of CME such as workshops, conferences, and seminars are helpful to bridge the gaps in practice. With advancing technologies, online format is used to deliver CME with appropriate

modifications. Although there are distinct advantages of online CME in regards to wider reach and flexibility, there are certain drawbacks beyond just technological limitations. Interactivity using ingenious ideas may be required to motivate and engage learners during online CME.

Keywords: Continuing medical education (CME), continuing professional development (CPD), online learning, distance education, telemedicine

Medical practitioners are expected to periodically update their knowledge and skills to keep abreast of the developments in their fields of practice. This is also mandated by the regulating bodies such as the Medical Council of India (MCI) and State Medical Councils (SMC).¹⁻³ A “clinical care gap,” which refers to the gap in practice from the available evidence to treat or manage a patient in a cer-