TELEPSYCHIATRY AND COVID-19: WHAT WE DO AND DO NOT KNOW

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Peer-reviewed,evidence-based information for clinicians and researchers in the field of neurotherapeutics

Telepsychiatry and Risk Management

ICN Online Editor | September 30, 2011 | 0 Comments

by Charles D. Cash, JD, LLM
Mr. Cash is Senior Risk Manager for Professional Risk Management Services, Inc., Arlington, Virginia.

Innov Clin Neurosci. 2011;8(9):26–30

Question

I am thinking about incorporating some form of telemedicine into my practice. I hope to expand my practice and be able to treat a few of my patients who live quite a distance from my office. A few of my colleagues have done this using their office desktop computers and software that allow high-quality video calling over the internet. Another colleague practices telemedicine through the hospital where he works. What do I need to consider before I take on a telemedicine endeavor?

Answer

As the use of technology in medicine rapidly expands, psychiatrists inevitably will consider how some of those technologies might be applied to their practices. Telemedicine is the use of technology to facilitate clinical care at a distance and includes, among many fields of telemedicine, telepsychiatry. Telemedicine technologies include, but are not limited to, telephone, e-mail, and real-time videoconferencing.

Telepsychiatry, if done well, can benefit patients. It also presents significant risks for the unwary. The following issues should be thoughtfully and carefully considered before adopting telepsychiatry into your practice.

Preliminary considerations

The first step in any telepsychiatry endeavor is to define what you want to do and how you will do it. This is essentially business planning; determining what services will be offered, to whom they will be offered, and the technology used to offer them. The article entit
provides a thorough discus

Top 10 Myths about Telepsychiatry

ICNS Online Editor | September 1, 2017 | 0 Comments

by Donna Vanderpool, JD

Ms. Vanderpool is Vice President, Risk Management, at PRMS, Inc.

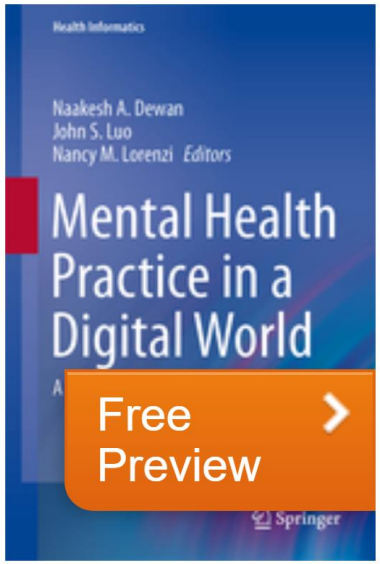
The technology for remote treatment is advancing rapidly. The regulatory environment in which psychiatrists practice telepsychiatry is also evolving but at a much slower pace than the technology. As introduced in this journal years ago by my colleague Charles D. Cash in his article, "Telepsychiatry and Risk Management,"[1] there is still a lack of uniformity in how—and even whether—states address telemedicine requirements. This discrepancy has resulted in many myths around this topic. Fortunately, we are starting to see some concepts evolving that are generally consistent, regardless of the state, allowing us to clear up some prevalent misunderstandings about telepsychiatry.

MYTH #1

Services are deemed to be rendered where the psychiatrist is located.

Reality. All states are clear that a healthcare provider's services are rendered where the patient is physically located at the time of treatment. This fact has several implications, including the following:

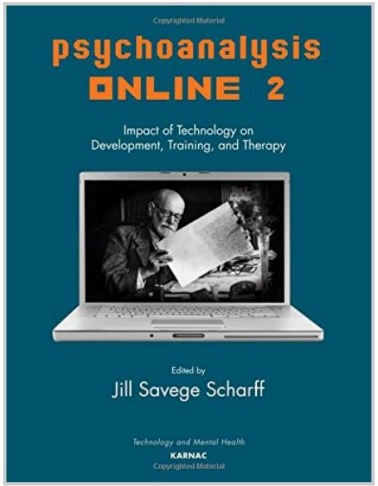
1. If the patient is in a different state than the provider, and the provider is not licensed in the patient's state, the patient's state licensing board should be contacted to determine whether licensure in the patient's state is required. While almost all states require some type of licensure or registration, the issue seems to be fact-specific (see Myth #2). Note that providers do not want to be found practicing without a license, as that could have criminal and medical malpractice insurance implications.
2. The provider will need to comply with all relevant laws not only in his or her own state (establishing a treatment relationship, prescribing requirements, duty to warn, etc.) but also in the patient's state.



Chapter 8
An Overview of Practicing High Quality Telepsychiatry

Donna Vanderpool

Abstract Providing psychiatric services remotely via telepsychiatry can be an effective care delivery model. Given the increasing need for psychiatric services, utilization of telepsychiatry is expected to increase for both consultation and treatment purposes. There are currently regulatory constraints, such as licensure, in-person examination, and prescribing requirements that pose significant barriers to the widespread adoption of telepsychiatry. However, these regulatory barriers are being evaluated by the states and are slowly being resolved. The steps to practicing quality telepsychiatry are: determine exactly what type of telepsychiatry you want to practice; determine how you want to practice and what technology will be used; address licensure requirements in the patient's state; address in-person examination and prescribing requirements in your state and the patient's state; address other



DISCLAIMERS

- Nothing presented here is legal advice
- Even prior to COVID-19, there were many telepsychiatry questions that had no answers
- There is little consistency in how states are addressing telemedicine

Music provided by www.Pond5.com

DISCLAIMERS

- Things can change daily
  - Federal regulators are relaxing requirements
  - States are relaxing requirements
- What is true today may not be true tomorrow

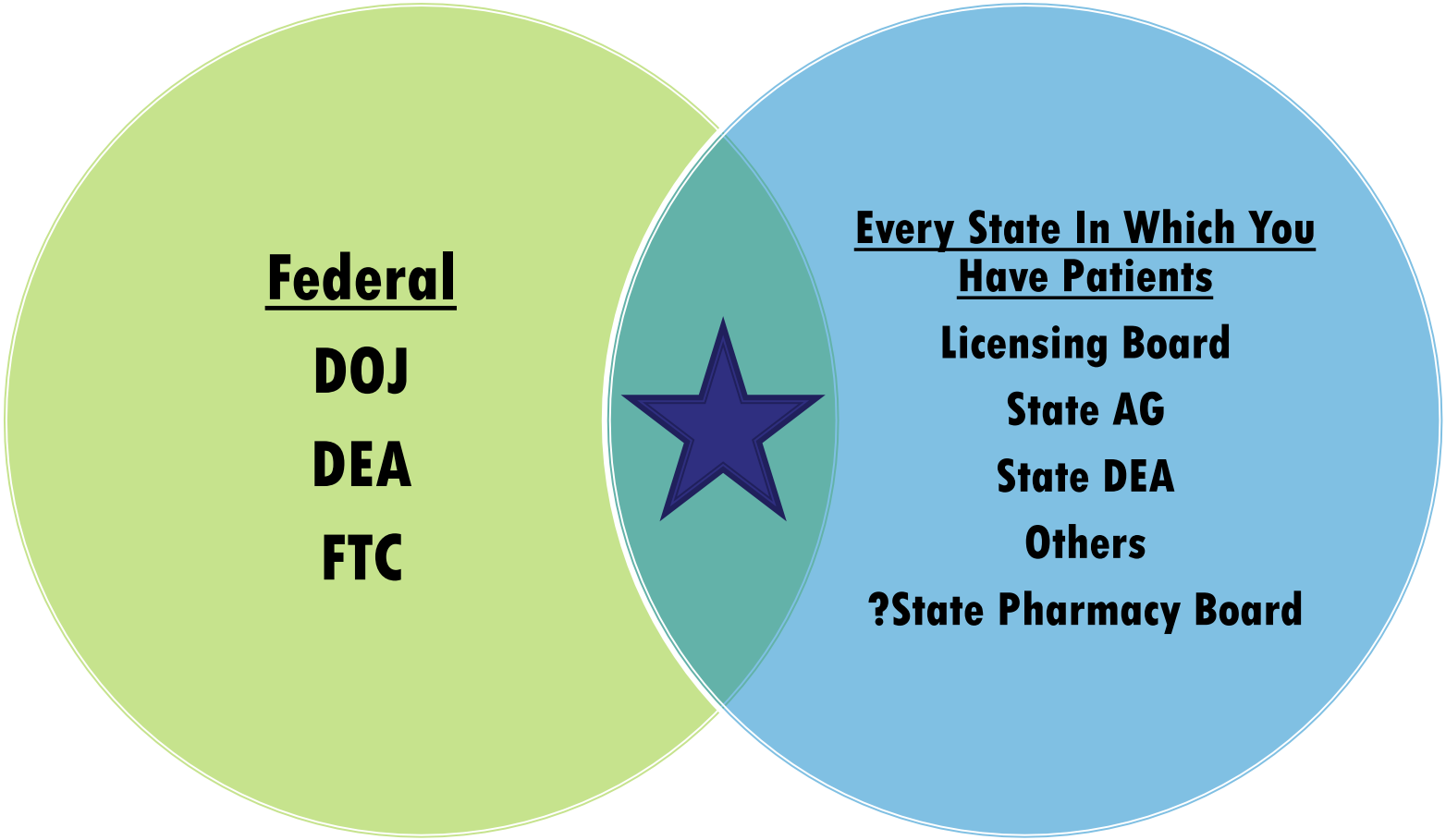
AGENDA

- Introduction
- Legal hurdles
- Clinical hurdles
- Prescribing issues
- Other issues
  - Preparing for post-PHE
  - Malpractice insurance
  - “How to’s”

THREE PHASES

- Phase 1
  - Pre-PHE
  - Rules unclear
- Phase 2
  - PHE
  - Rules totally unclear due to regulatory actions and inaction
- Phase 3
  - Post-PHE
  - No crystal ball

REGULATORS OF PHYSICIANS



TELEPSYCHIATRY CHECKLIST – MODIFIED PER CORONAVIRUS UPDATES (5/21/20)

- ☐ I have reviewed my state's law on telemedicine, including, but not limited to:
  - ☐ In-person examination requirements
  - ☐ Prescribing requirements

  3/19/20: States may be relaxing some of these requirements given the need for individuals to stay home.

- ☐ If a patient will be treated in a different state:
  - ☐ Licensure
    - ☐ I am licensed in the patient's state, all state requirements are met (CME requirements, PMP requirements, etc...)

      OR
    - ☐ A license in that state is not required (3/9/20)

    3/19/20: States MAY be relaxing licensure requirements, but it may be only in limited circumstances, such as only to treat patients in a hospital, or only if actually treating the coronavirus.

  - ☐ Law
    - ☐ I have reviewed the law on telemedicine in the patient's state, including, but not limited to:
      - ☐ In-person examination requirements
      - ☐ Prescribing requirements

    3/19/20: States have been slow to offer licensure waivers and even slower to address state treatment laws. The risk management advice is to do what you can. For example, a state may require written informed consent for the use of telemedicine. That may or may not be possible; if not possible, providers can obtain verbal consent and document that verbal consent to telemedicine.

- ☐ I am using HIPAA-compliant equipment
  - ☐ If the equipment vendor stores any patient information, I have a Business Associate Agreement from the vendor

  3/19/20: The federal government has exercised "its enforcement discretion and will waive potential penalties against health care providers that serve patients through everyday communication technologies during the COVID-19 nationwide public health emergency. This exercise of discretion applies to widely available communication apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19."

Coronavirus FAQs

UPDATED: June 9, 2020

NOTE: Please remember that we are all operating in uncharted territory and there are very few clear answers. This is a very fluid situation and recommendations may change based upon events or guidance from the federal and state governments. Please check back often for updates.

IF YOU ARE NOT INSURED THROUGH PRMS: Please do not rely on this information as more than one company's risk management thoughts. Nothing presented here is legal advice. You should check with your own risk managers.

Quick Links:

- State Licensure Waiver Information
- Telepsychiatry Checklist **(Updated 5/21/20)**
- Preparing For What's Next - To Do List **(NEW RESOURCE)**

INTERNET PRESCRIBING

- **Internet prescribing based solely on online questionnaire**
  - **Two regulatory prohibitions:**
    - **For providers: States regulate prescribers – and prohibit prescribing based solely on an online questionnaire**
    - **Pharmacies: Online pharmacies cannot fill prescriptions based solely on an online questionnaire**
      - **Ryan Haight Act – amends Controlled Substances Act**

FEDERAL REGULATION OF INTERNET PRESCRIBING

- **Controlled Substance Act**
  - **21 USC § 829(e) – Controlled Substances Dispensed By Means of the Internet**
    - **"No controlled substance that is a prescription drug…may be delivered, distributed or dispensed by means of the Internet without a valid prescription."**
    - **"Valid prescription means a prescription that is issued for a legitimate medical purpose in the usual course of professional practice by –**
      - **A practitioner who has conducted at least 1 in-person medical evaluation of the patient, or a covering practitioner**
      - **In-person medical evaluation means a medical evaluation that is conducted with the patient in the physical presence of the practitioner"**

TELEPSYCHIATRY

- Providing psychiatric services remotely, typically through videoconferencing
  - Psychiatrist and patient are in different locations
- We are NOT talking about a patient on short vacation who needs prescription called in

TELEPSYCHIATRY

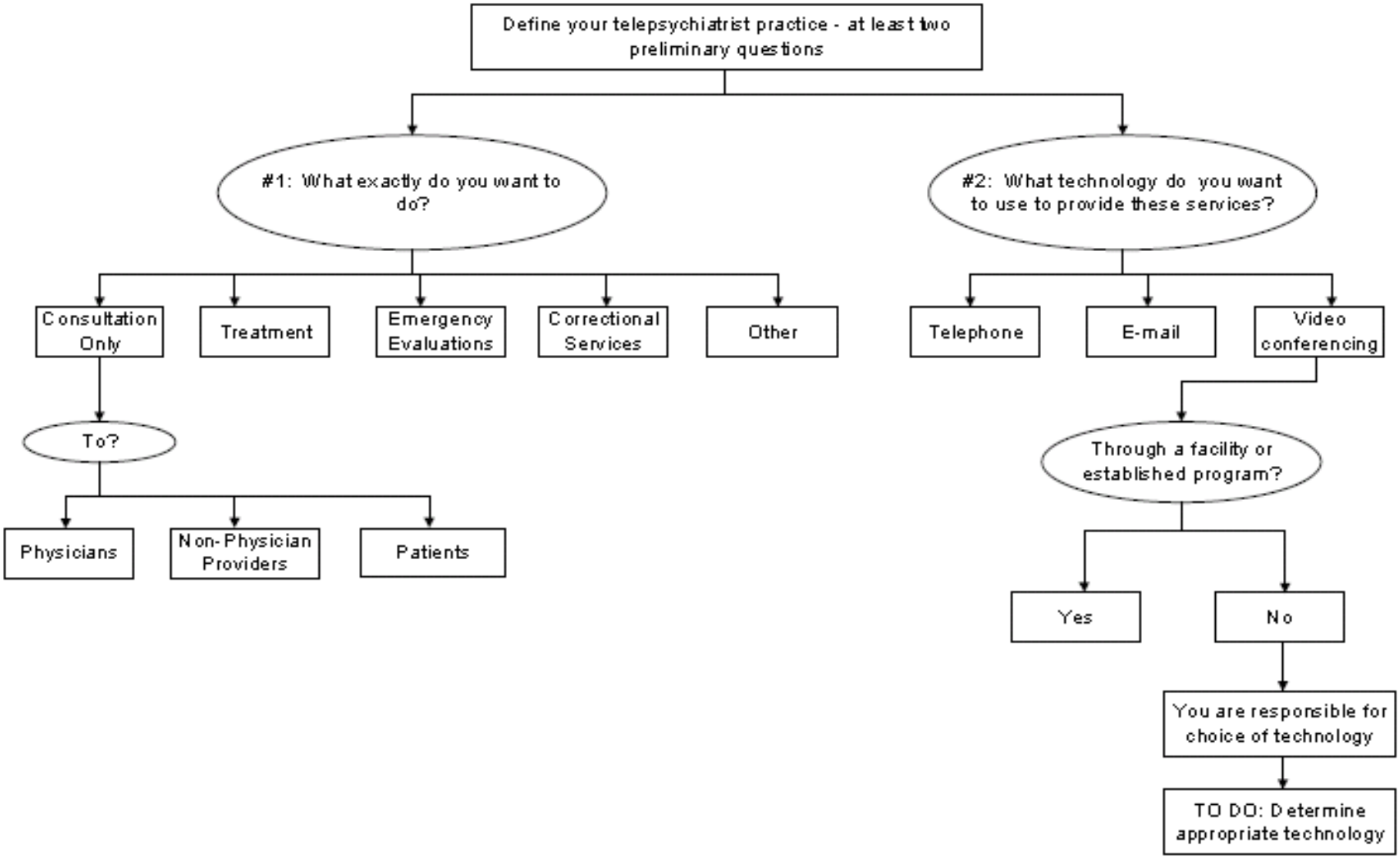
- Telephone treatment may or may not be considered telemedicine
  - Don't be confused by state Medicaid laws:
    - Typically say state won't reimburse for phone calls
      - Compliance with all state laws, including licensure laws, is still required

EVEN IF NOT TECHNICALLY TELEMEDICINE…

- **You still need to meet the standard of care**
- **If patient is in a different state, you may still need a license in the patient's state**

TELEPSYCHIATRY

PRELIMINARY DETERMINATIONS



HIPAA REQUIREMENTS

- Privacy Rule
  - Business Associate Agreement if has access to PHI
    - Check Privacy Policy
- Breach Notification Rule
  - BA must notify covered entity of any breach
- Security Rule
  - Encryption
  - BA must provide audit trails – who has accessed PHI
  - Include telepsych activities in Security Risk Assessments

HHS.gov

U.S. Department of Health & Human Services

Health Information Privacy

I'm looking for...

HHS A-Z Index

HIPAA for Individuals | Filing a Complaint | HIPAA for Professionals | Newsroom

HHS > HIPAA Home > For Professionals > Special Topics > Emergency Response

- HIPAA for Professionals
- Regulatory Initiatives
- Privacy +
- Security +
- Breach Notification +
- Compliance & Enforcement +
- Special Topics −
  - HIPAA and COVID-19
  - Mental Health & Substance Use Disorders
  - De-Identification Methods

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Emergency Situations: Preparedness, Planning, and Response

The Privacy Rule protects individually identifiable health information from unauthorized or impermissible uses and disclosures. The Rule is carefully designed to protect the privacy of health information, while allowing important health care communications to occur. These pages address the release of protected health information for planning or response activities in emergency situations. In addition, please view the Civil Rights Emergency Preparedness page to learn how nondiscrimination laws apply during an emergency.

COVID-19 and HIPAA

We are empowering medical providers to serve patients wherever they are during this national public health emergency. We are especially concerned about reaching those most at risk, including older persons and persons with disabilities. – Roger Severino, OCR Director.

During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, the HHS Office for Civil Rights (OCR) has provided guidance that helps explain how the HIPAA Privacy Rule allows patient information to be shared in the outbreak of infectious disease and to assist patients in receiving the care they need.

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

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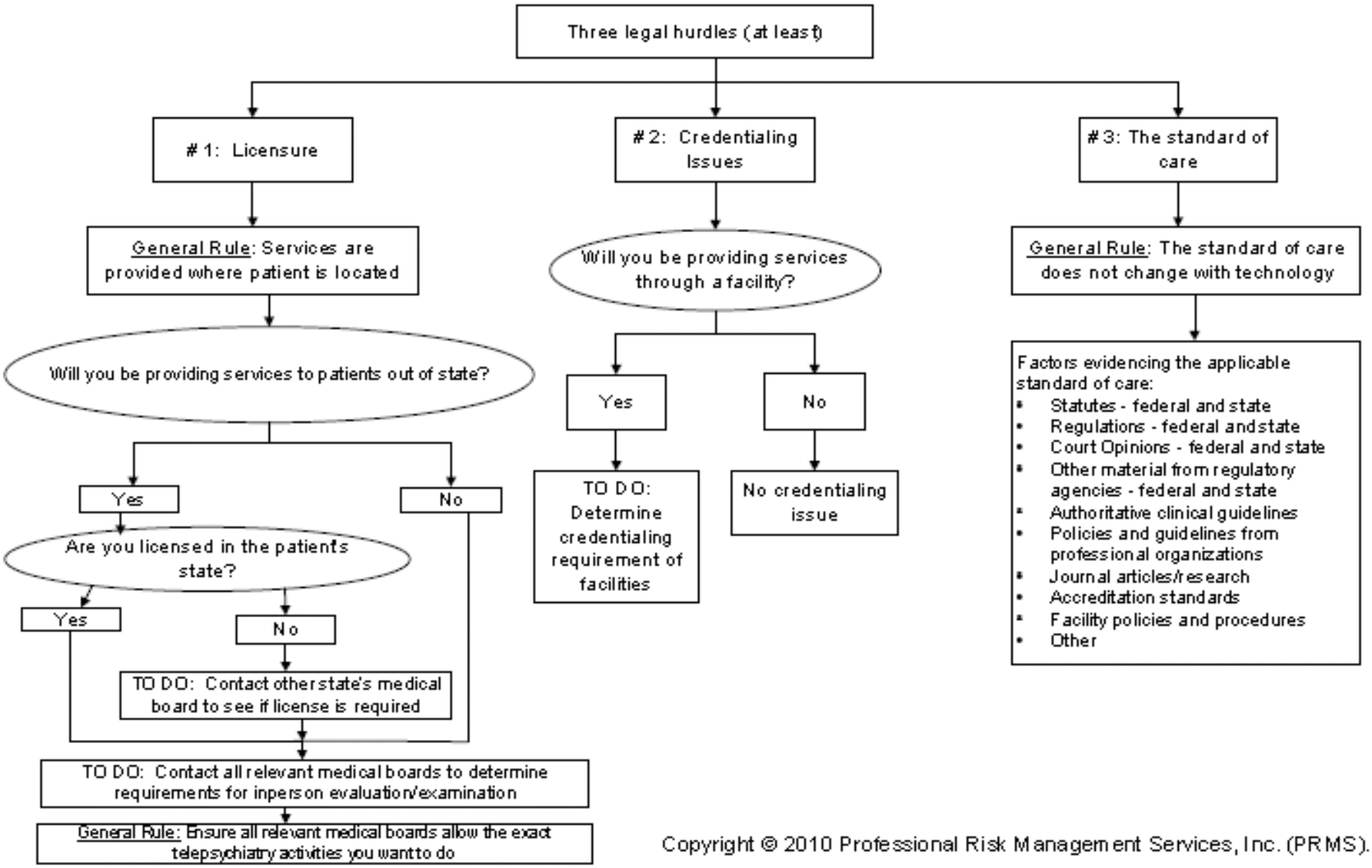
TELEPSYCHIATRY

LEGAL HURDLES



TAKE AWAY POINT #1

Treatment is rendered where the patient is physically located.

WHERE ARE TELEMEDICINE SERVICES RENDERED?

From the boards:

- **NY: "It is the location of the patient that defines where the care has been delivered and the jurisdiction of applicable regulations"**

- **SC: "The Board adheres to the view that the practice of medicine occurs where the patient is physically located"**

STATE LICENSURE REQUIREMENTS

- **Varies by state**
  - **Full license**
  - **Special purpose / telemedicine license**
  - **Just registration**
- **Can be exceptions**

NEW JERSEY (last update 4/3/2020)

General and Telemedicine: Allows for **application for accelerated temporary healthcare licensure** by reciprocity for out-of-state providers including those practicing telemedicine. Licenses granted pursuant to this provision will be valid for 180 days, with an additional 180-day extension available upon written request.

Source: https://www.njconsumeraffairs.gov/Pages/Temporary-Emergency-License-for-Out-of-State-Practitioners.aspx

TYPICAL TOPICS ADDRESSED IN TELEMEDICINE LAWS

- Informed consent
- Medical records
- Confidentiality and security
- Physician-patient relationship
- Follow-up care
- Verification of patient's identity
- Etc.

IN-PERSON EXAMINATION / FACE-TO-FACE EVALUATION

- Federal law (Ryan Haight Act)
- State law - no uniformity
  - Some boards do not address it
  - Some boards say in-person exam is not required
  - Some boards say it depends
    - On where the patient is located
    - On prescribing

AMA AMERICAN MEDICAL ASSOCIATION

Advocacy Resource Center

Advocating on behalf of physicians and patients at the state level

50-state survey: Establishment of a patient-physician relationship via telemedicine

The following compilation of state laws may be useful to state and national specialty medical societies in advocacy related to efforts to telemedicine laws or regulations that define establishment of a patient-physician relationship for purposes of treatment telemedicine.

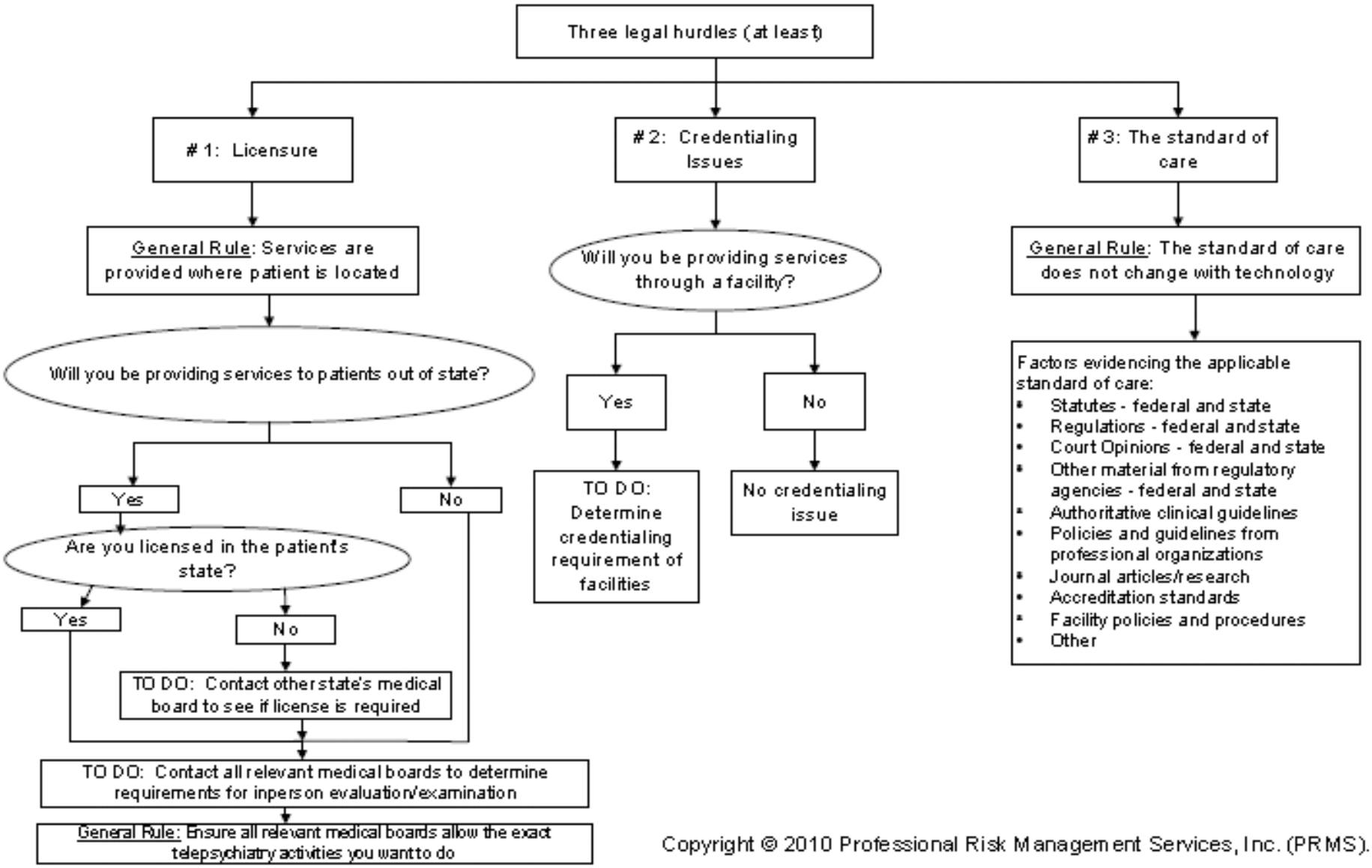
All states allow a physician to establish a relationship with a new patient via telemedicine, though state laws differ. A few states include some caveats to that general rule, restricting the setting in which a patient must be located in order to establish the patient-physician relationship (e.g. limiting to established medical site), or the modalities that can be used to establish such a relationship (e.g. telephone versus two-way audio and video technology). More details on each state's laws and regulations are below.

The AMA believes that a valid patient-physician relationship must be established before the provision of telemedicine services, through: (i) A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or (ii) A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or (iii) Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology. Exceptions include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services. (Policy H-480.948, Coverage of and Payment for Telemedicine.)

State	Statute	Establish relationship via telemedicine?	Notes
Alabama	AAC 540-X-15-.09	Only at established medical site (& other exceptions including mental	Separate rules for telemedicine provided at a medical site vs non-medical site. **Telehealth Medical Services Provided at an Established Medical Site** ▪ Telehealth medical services provided at an established medical site may be used for all patient visits, including initial evaluations to establish a provider-patient relationship.

TELEPSYCHIATRY

LEGAL HURDLES



TAKE AWAY POINT #2

Utilizing telemedicine does not alter the standard of care to which the physician will be held – it is the same standard of care that would apply if the patient was in the physician's office or facility.

TELEMEDICINE - STANDARD OF CARE

From the Medical Board of California:

"The standard of care is the same whether the patient is seen in-person, through telemedicine or other methods of electronically enabled health care."

"In summary, the law governs the practice of medicine, and no matter how communication is performed, the standards are no more or less…Physicians practicing via telemedicine are held to the same standard of care, and retain the same responsibilities of providing informed consent, ensuring the privacy of medical information, and any other duties associated with practicing medicine."

Practicing Medicine Through Telemedicine Technology, www.mbc.ca.gov/Licensees/Telehealth.aspx

FACTORS THAT MAY EVIDENCE THE STANDARD OF CARE

- Statutes – federal and state
- Regulations – federal and state
- Court opinions – federal and state
- Other regulatory materials – federal and state (such as state medical boards)
- Authoritative clinical guidelines
- Policies and guidelines from professional organizations
- Journal / research articles
- Accreditation standards
- Facility policies and procedures

FROM RHODE ISLAND

Medical Board Guidelines -

Informed Consent:

Delivery of medical services via the Internet requires expanded responsibility on the part of the physician in informing and educating the patient. A patient has the right to know what personal data may be gathered and by whom. Limitations as defined within HIPAA and the HITECH act should be observed and followed. It should be clearly explained to patients when online communication should not take the place of an in-person interaction with a health care provider.

www.health.ri.gov/publications/guidelines/provider/AppropriateUseOfTelemedicineAndTheInternetInMedicalPractice.pdf

FROM RHODE ISLAND

Medical Board Guidelines -

Section Three: An Appropriate Physician-Patient Relationship

…

It is the physician who has the professional responsibility to consider these differences [in telemedicine] in their evaluation and management of the patient…

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the BMLD that physicians recognize the obligations, responsibilities and patient rights associated with establishing and maintaining an appropriate physician-patient relationship whether or not face –to-face contact between physician and patient has occurred. However, when a patient's clinical presentation suggests the need for an in-person physical examination, the patient should be referred for an in-person evaluation which is documented in the medical record. Failure to make necessary referrals or progressions to treatments without doing so constitutes unprofessional conduct…

www.health.ri.gov/publications/guidelines/provider/AppropriateUseOfTelemedicineAndTheInternetInMedicalPractice.pdf

FROM NORTH CAROLINA

Different Medical Board Position Statement – *Availability of Licensees to their Patients*

It is the position of the North Carolina Medical Board that once a relationship between a licensee and a patient is created, it is the duty of the licensee to provide care whenever it is needed or to assure that proper backup by a healthcare provider is available to take care of the patient during or outside normal office hours.

If the licensee is not going to be available after hours, the licensee must provide clear instructions to the patient for securing after-hours care. It is the responsibility of the licensee to ensure that the patient has sufficient information regarding how to secure after-hours care.

It should be noted that these duties are applicable to a licensee whether the licensee is practicing telemedicine or practicing medical through traditional means.

www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/availability_of_licensees_to_their_patients

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TELEMENTAL / TELEBEHAVIORAL SURVEY

50-State Survey on Telemental Health Laws in the United States

Epstein Becker Green is pleased to present the **50-State Survey of Telemental/Telebehavioral Health (2016),** a groundbreaking, comprehensive survey on the laws, regulations, and regulatory policies impacting telemental health in all 50 states and the District of Columbia.

While other telehealth studies exist, this survey is focused solely on the remote delivery of *behavioral* health care.

Compiled by attorneys in Epstein Becker Green's Telehealth & Telemedicine practice, the survey details the rapid growth of telemental health—mental health care delivered via interactive audio or video, computer programs, or mobile applications—and the increasingly complex legal issues associated with this trend. Additionally, the survey provides one source for state-by-state coverage of legal issues related to telemental health, such as:

- Definitions of "telehealth" or "telemedicine"
- Licensure requirements
- Governing bodies
- Reimbursement and coverage issues
- The establishment of the provider-patient relationship
- Provider prescribing authority
- Accepted modalities for delivery (e.g., telephone, video) to meet standards of care

Associated Practices

Behavioral Health

Digital Health

Telehealth & Telemedicine

Telemental/Telebehavioral Health

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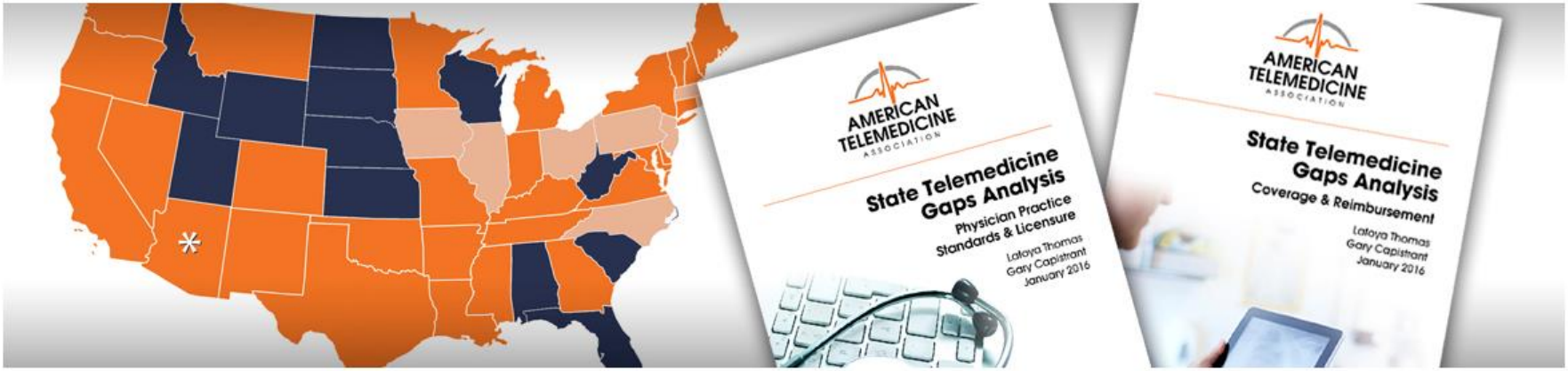


STATE TELEMEDICINE GAPS REPORTS

www.americantelemed.org/policy-page/state-telemedicine-gaps-reports

Center for Connected Health Policy
The National Telehealth Policy Resource Center

Telehealth policies for all 50 states

About CCHP | CCHP Projects | What is Telehealth? | Telehealth Policy | Resources

Telehealth Policy

National Policy

- State Laws and Reimbursement Policies
- Medicare
- Medicaid
- Legal Barriers
- Health Information Technology
- HIPAA
- The Federal Trade Commission and Professional Licensure Boards

California Policy

- Medi-Cal
- Telehealth Advancement Act

Arizona

Use these filters to view specific areas or types of law. Use the "status" filter to view pending law.

Area of Law	Law Type	Status	
Broadband Demonstrations & Pilot Projects Network Adequacy Professional Board Regulation Provider-Patient Relationship/In-Person Exam Telemedicine/Telehealth Definition Live Video Reimbursement Store and Forward Reimbursement	- Any -	Current	Apply

TELEMEDICINE/TELEHEALTH DEFINITION

LAW

Under Arizona Statute, Public Health & Safety, "telemedicine means the practice of health care delivery, diagnosis, consultation and treatment

REGULATION

Under State Administrative Code, Department of Insurance, Health Care Services Organizations Oversight, "telemedicine means diagnostic

MEDICAID PROGRAM

Service delivery via telemedicine can be in one of two models: Real time means the interactive, two-way transfer of information and medical data

Federation of STATE MEDICAL BOARDS

Telemedicine Policies

Board by Board Overview

Document Summary:

- Forty-eight (48) state boards, plus the medical boards of District of Columbia, Puerto Rico, and the Virgin Islands, require that physicians engaging in telemedicine are licensed in the state in which the patient is located.
- Fifteen (15) state boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.
- Four (4) state boards require physicians to register if they wish to practice across state lines.
- Twenty-eight (28) states, plus the District of Columbia, require both private insurance companies and Medicaid to cover telemedicine services to the same extent as face-to-face consultations.
- Eighteen (18) states currently require only Medicaid to cover telemedicine services.
- One (1) state requires only private insurance companies to reimburse for services provided through telemedicine.

	State License	Reimbursement Parity	Other Rules/Regulations (citation only)

State Medical Board of Ohio

Position Statement on Telemedicine

The Medical Board has received increased inquiries from providers, patients, and businesses related to status of telemedicine and telehealth in Ohio. As such the Medical Board has been meeting with these interested parties in a concerted effort to ensure a viable framework for telemedicine moving forward.

The Medical Board recognizes that technological advances have made it possible for licensees to provide medical care to patients in ways that were not feasible in the past. As a result, telemedicine is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and potential reductions in the cost of patient care.

Federation of STATE MEDICAL BOARDS

FOR IMMEDIATE RELEASE

Contact: Drew Carlson, (817)868-4043;

dcarlson@fsmb.org

State Medical Boards Adopt Policy Guidelines for Safe Practice of Telemedicine

Denver, Colorado (April 26, 2014) – Representatives of state medical licensing boards today approved updated guidelines to help ensure the safety and quality of medicine when it is practiced using telemedicine technology – which can connect a patient in one location with a care provider in another location.

The *Model Policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*, adopted by the Federation of State Medical Boards (FSMB), provides much-needed guidance and a basic roadmap that state boards can use to ensure that patients are protected from harm in a fast-changing health-care delivery environment.

Among its key provisions, the model policy states that the same standards of care that have historically protected patients during in-person medical encounters must apply to medical care delivered electronically. Care providers using telemedicine must establish a credible "patient-physician relationship," ensuring that patients are properly evaluated and treated and that providers adhere to well-established principles guiding privacy and security of personal health information, informed consent, safe prescribing and other key areas of medical practice.

"Telemedicine offers wonderful tools to help expand treatment options for patients – particularly in helping provide care in remote areas, lowering costs and helping support preventive care efforts," said FSMB President and CEO Humayun J. Chaudhry, DO, MACP. "But as telemedicine has grown, so too, has the need for clear, common-sense guidelines that help health care providers transition to this exciting new environment in a safe way."

Dr. Chaudhry noted that the new guidelines are designed to provide flexibility in the use of technology by physicians – ranging from telephone and email interactions to videoconferencing – as long as they adhere to widely recognized standards of patient care.

Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup

Introduction

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)[1] and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients[2] via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of

[1] The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).
[2] The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.

www.fsmb.org/Media/Default/PDF/Publications/FSMB%20Telemedicine%20Policy%20News%20Release_042614.pdf
www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf

Best Practices in Videoconferencing-Based Telemental Health (April 2018)

The American Psychiatric Association

and

The American Telemedicine Association

Resource Document on Telepsychiatry and Related Technologies in Clinical Psychiatry

APA Council on Psychiatry & Law

Special Acknowledgment

Patricia Recupero, M.D., J.D.
Carl Erik Fisher, M.D.

Approved by the Joint Reference Committee
January 2014

Abstract

The goal of this resource document is to address the major areas of the use of the Internet in communication with patients and the public in the practice of psychiatry. The rate of change of technological capabilities and their implementation is so rapid that the workgroup believes that it would be inappropriate to promulgate fixed rules for constantly changing situations. Rather, we seek to provide some questions to be considered when implementing any new communication technology with patients or the public. This document seeks to address professional use of the Internet and does not discuss issues related to psychiatrists' use of social media and social networking sites such as Facebook or Twitter. In order to assist the practitioner, references to resource materials will be given. However, the reference is not an endorsement by either the APA or the members of the work group of the material contained therein.

As with the addition of any relatively new technology, there are complicated legal and ethical issues to consider, and it is beyond the scope of this resource document to provide an exhaustive list of the relevant concerns. This document aims, instead, to provide a general introduction to the use of the Internet in clinical psychiatry, to identify some of the key issues arising from the debate, and to provide some starting-point resources for physicians and other practitioners who may be interested in learning more about this developing area in health services. We expect that the prudent practitioner will use this document as a starting point only and that a more thorough investigation or research effort will be conducted before acting. The role of the Internet in medicine is an unsettled area of the law. There are few specific appellate court rulings on these issues. Often, reasoning from analogy is applied. The legal implications suggested herein may not be applicable in any or all jurisdictions. This resource document is not intended to be construed as a clinical practice guideline, nor to define a standard of care.

Journal of the American Academy of
CHILD & ADOLESCENT
PSYCHIATRY

Volume 47, Issue 12, Pages 1468-1483 (December 2008)

Practice Parameter for Telepsychiatry With Children and Adolescents

Accepted 19 July 2008.

Abstract

This practice parameter discusses the use of telepsychiatry to provide services to children and adolescents. The parameter defines terms and reviews the status of telepsychiatry as a mode of health service delivery. Because many of the issues addressed are unique to telepsychiatry, the parameter presents principles for establishing a telepsychiatry service and optimizing clinical practice within that service. The principles presented are based on existing scientific evidence and clinical consensus. Telepsychiatry is still evolving, and this parameter represents a first approach to determining “best practices.” The parameter emphasizes the integration of telepsychiatry within other practice parameters of the American Academy of Child and Adolescent Psychiatry. *J. Am. Acad. Child Adolesc. Psychiatry*, 2008;47:(12)1468–1483.

AMERICAN TELEMEDICINE ASSOCIATION

PRACTICE GUIDELINES FOR TELEMENTAL HEALTH WITH CHILDREN AND ADOLESCENTS

MARCH 2017

TAKE AWAY POINT #3

Contact all applicable medical boards
to determine if you can do what you want to do
without violating applicable laws!

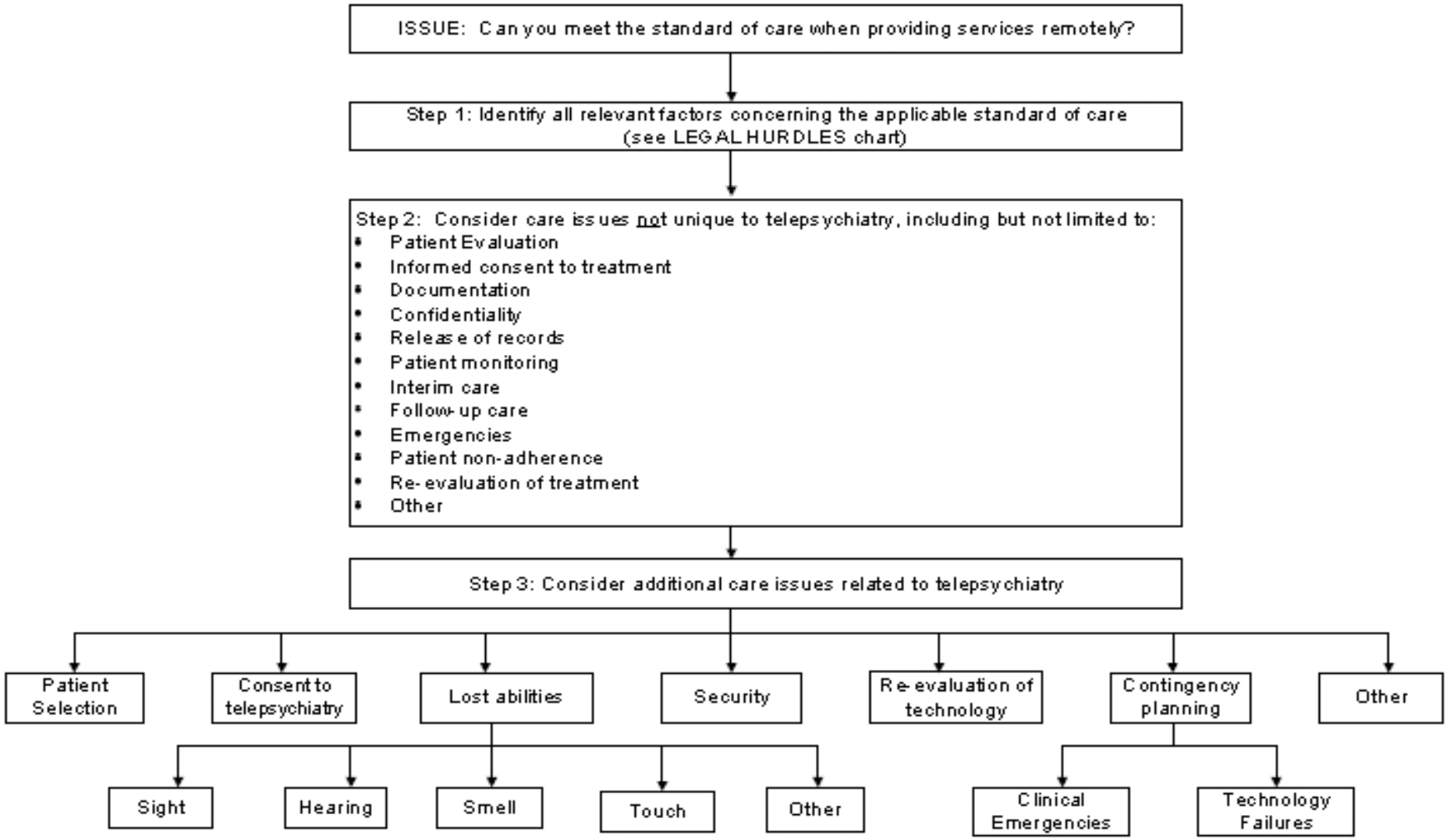
- **Licensure requirements?**
- **In-person physical examination required?**
- **?**

AGENDA

- Introduction
- Legal hurdles
- Clinical hurdles
- Prescribing issues
- Other issues
  - Preparing for post-PHE
  - Malpractice insurance
  - “How to’s”

TELEPSYCHIATRY

CLINICAL HURDLES



TECHNOLOGY IS ONLY A TOOL

Technology is a tool that can partially restore the lost abilities to evaluate and treat patients at a distance, but by itself, *technology cannot completely restore all abilities.*

AGENDA

- Introduction
- Legal hurdles
- Clinical hurdles
- **Prescribing issues**
- Other issues
  - Preparing for post-PHE
  - Malpractice insurance
  - “How to’s”

Prescribing Controlled Substances via Telepsychiatry: Compliance with State and Federal Law

Compliance with State Prescribing Law

Is prescribing controlled substances via telemedicine allowed by prescriber's state and patient's state (if different)?

PRESCRIBING CONTROLLED SUBSTANCES VIA TELEMEDICINE

- **No uniformity**
  - **Some boards do not address it**
  - **Some boards say yes**
  - **Some boards say no**
  - **Some boards say no, then yes in some cases!**

If prescribing controlled substances via telemedicine allowed by prescriber's state and patient's state (if different), under what conditions?

State Profiles

NASCSA
National Association of State Controlled Substances Authorities

Home | Conference 2015 | Conference 2016 | NEWS | RSS Feed

www.nascsa.org/stateprofiles.htm

Events | Let's Get Social! | Get in touch!

Compliance with Federal Controlled Substances Act

U. S. Department of Justice
Drug Enforcement Administration
8701 Morrissette Drive
Springfield, Virginia 22152

www.dea.gov

DEA Registrants

Dear Registrant:

The Controlled Substances Act (CSA) provides that every person who dispenses, or who proposes to dispense, any controlled substance shall obtain from the Drug Enforcement Administration (DEA) a registration issued in accordance with DEA rules and regulations. *See* 21 U.S.C. 822(a)(2). DEA may only register a person to dispense a controlled substance if that person is permitted to do so by the jurisdiction in which he or she practices. *See id*. 802(21), 823(f). Thus, unless subject to an applicable exception, DEA regulations require a practitioner to obtain a separate DEA registration in each state in which he or she dispenses a controlled substance. The DEA Administrator, however, is permitted by 21 CFR 1307.03 to grant an exception to the application of any provision in the DEA regulations codified in Chapter II of Title 21 of the CFR. This authority has been redelegated to the Assistant Administrator of the Diversion Control Division.

On January 31, 2020, the Secretary of Health and Human Services (HHS) declared a public health emergency with regard to COVID-19.[1] Many states also have declared public emergencies and granted reciprocity to neighboring states and their practitioners with regard to medical licensing requirements. As such, practitioners in such states are now permitted by state law to dispense controlled substances not only in their home states but also in states with which their home states have reciprocity. The requirement of a separate DEA registration in each state where the practitioner dispenses controlled substances is a core requirement essential to diversion control that would not normally be subject to an exception under 21 CFR 1307.03. However, in view of the extraordinary circumstances that have arisen during this public health emergency, and in order to ensure adequate medical care for the duration of this public health emergency, DEA will **grant** an exception for practitioners in such states to those provisions of DEA regulations that normally require practitioners to register in each state where they dispense controlled substances. Under the exception being announced today, DEA-registered practitioners are not required to obtain additional registration(s) with DEA in the additional state(s) where the dispensing (including prescribing and administering) occurs, for the duration of the public health emergency declared on January 31, 2020, if authorized to dispense controlled substances by both the state in which a practitioner is registered with DEA and the state in which the dispensing occurs. Practitioners, in other words, must be registered with DEA in at least one state and have permission under state law to practice using controlled substances in the state where the dispensing occurs.

The practitioner must continue to comply with the laws and regulations of the state in which

[1] For information regarding DEA's response to COVID-19, see https://www.deadiversion.usdoj.gov/coronavirus.html.

they are registered, and the laws and regulations of the state in which they are practicing, if different. Thus, where one state's law and regulations are more restrictive than the other state's law and regulations, the practitioner generally must follow the more restrictive law and regulations. That said, a practitioner may be operating under a state reciprocity agreement or other form of state permission that authorizes the practitioner to comply only with the normally applicable law or regulations of either the state in which they are registered or the state in which they are practicing. In other words, states may deem compliance with one state's normally applicable law and regulations as compliance with both states' laws and regulations. Under this circumstance, DEA would understand the practitioner to be complying with both states' laws and regulations because the practitioner's actions would be authorized by both states.

The exception granted in this letter also applies to the prescription of controlled substances via telemedicine to patients in states in which a practitioner is not DEA-registered. Under the CSA, a prescription for a controlled substance issued by means of the Internet must generally be predicated on an in-person medical evaluation. *See* 21 U.S.C. 829(e)(1). This requirement does not apply, however, when a practitioner is practicing telemedicine as defined by the CSA. The CSA's definition of the practice of telemedicine includes multiple different categories of telemedicine. For several of these categories, the CSA specifically requires a practitioner to have a DEA registration in the state in which the patient is located. *See, e.g., id*. 802(54)(A), (B). But the practice of telemedicine during a public health emergency pursuant to 21 U.S.C. 802(54)(D) does not include this requirement. On March 16, 2020, the Secretary of HHS, with concurrence of the Acting DEA Administrator, designated that the telemedicine allowance under section 802(54)(D) applies to all schedule II-V controlled substances in all areas of the United States. Thus, in light of this designation and subject the conditions of this letter's temporary exception, DEA-registered practitioners may prescribe controlled substances to patients in states in which they are not registered with DEA via telemedicine.

This exception is granted from March 23, 2020, through the duration of this public health emergency as declared by the Secretary of HHS. Practitioners are not required to apply for this exception from DEA regulations individually; rather, by this announcement, DEA has granted this exception to all DEA-registered practitioners who satisfy its conditions.

We hope this information is helpful. For information regarding DEA's Diversion Control Division please visit www.DEAdiversion.usdoj.gov. Please contact the Diversion Control Division, Policy Section at (571) 362-3260 if you seek additional assistance regarding this or any other matter.

Sincerely,

WILLIAM MCDERMOTT
Digitally signed by WILLIAM MCDERMOTT
Date: 2020.03.25 12:27:28 -04'00'

William T. McDermott
Assistant Administrator,
Diversion Control Division.

DEA067 – March 25, 2020

FEDERAL REGULATION

- **Controlled Substances Act**
  - **Amended in 2008 by the Ryan Haight Online Pharmacy Protection Act - 21 USC § 829(e)(3)**

FEDERAL REGULATION

- **Controlled Substances Act (as amended by the Ryan Haight Act)**
  - **"No controlled substance that is a prescription drug…may be delivered, distributed or dispensed by means of the Internet without a valid prescription."**
    - **Note: "dispense" is defined in §802(10) to include prescribing**

FEDERAL REGULATION

- **Controlled Substances Act (as amended by the Ryan Haight Act)**
  - **"Valid prescription means a prescription that is issued for a legitimate medical purpose in the usual course of professional practice by –**
    - **A practitioner who has conducted at least 1 in-person medical evaluation of the patient, or a covering practitioner**
      - **In-person medical evaluation means a medical evaluation that is conducted with the patient in the physical presence of the practitioner**

FEDERAL REGULATION

- **Controlled Substances Act (as amended by the Ryan Haight Act)**
    - **Exception to the in-person visit requirement is "telemedicine"**
        - ***But as defined by the CSA***

FEDERAL REGULATION

- **Controlled Substances Act (as amended by the Ryan Haight Act)**
  - **7 definitions of telemedicine / 7 exceptions to in-person visit**
    1. **Patient in facility with federal DEA registration**
    2. **Patient in presence of a treater with DEA registration in patient's state**
    3. **Indian Health Service**
    4. **Public health emergency**

U.S. DEPARTMENT OF JUSTICE ★ DRUG ENFORCEMENT ADMINISTRATION

DIVERSION CONTROL DIVISION

Search

HOME | REGISTRATION | REPORTING | RESOURCES | ABOUT US

COVID-19 Information Page

COVID-19 Information Page

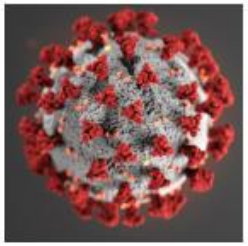
Get Email Updates:

Prescriptions | Registration | Quota |National Drug Supply | EPCS | Telemedicine | Medication Assisted Treatment | Records and Reports | Contacts | Important Federal Links | Important State Links

- Program Description
- Contact Us
- Customer Service Plan
- DEA Forms & Applications
- Mailing Addresses
- Meetings & Events
- Privacy Notice
- What's New

The mission of Drug Enforcement Administrations (DEA), Diversion Control Division is to prevent, detect, and investigate the diversion of controlled pharmaceuticals and listed chemicals from legitimate sources while ensuring an adequate and uninterrupted supply for legitimate medical, commercial, and scientific needs.

During this National Emergency the Diversion Control Division will continue to work with our Federal partners, DEA registrants, and their representative association to assure that there is an adequate supply of controlled substances in the United States. The DEA will also work to assure that patients will have access to controlled substances.



Questions and Answers

Prescriptions

DEA Policy: Registrant Guidance on Controlled Substance Prescription Refills

DEA Policy: Exception to Separate Registration Requirements Across State Lines

Registration

Registration of Emergency Temporary Sites: If you need to set up an emergency or temporary off-site location and use controlled substances, please contact DEA at **Natural.Disaster@usdoj.gov**. DEA will issue you a temporary registration number for each designated alternate location. This will enable the drug supply chain to continue uninterrupted and maintain patient access to needed controlled substances.

DEA Policy: Exception to Separate Registration Requirements Across State Lines

https://www.deadiversion.usdoj.gov/coronavirus.html

FEDERAL REGULATION

- **Controlled Substances Act (as amended by the Ryan Haight Act)**
  - **7 definitions of telemedicine / 7 exceptions to in-person visit**
    5. **Special registration from Attorney General**
    6. **Medical emergency**
    7. **Other circumstances, as deemed by Attorney General and Secretary**

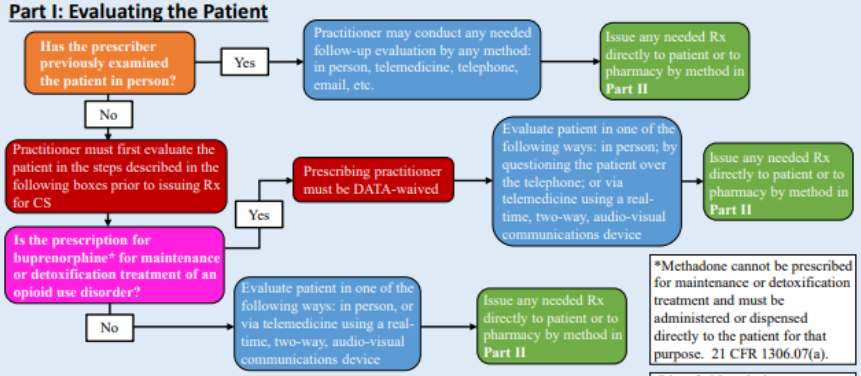
How to Prescribe Controlled Substances to Patients During the COVID-19 Public Health Emergency

In response to the COVID-19 public health emergency declared by the Secretary of Health and Human Services, the Drug Enforcement Administration (DEA) has adopted policies to allow DEA-registered practitioners to prescribe controlled substances without having to interact in-person with their patients. This chart only addresses prescribing controlled substances and does not address administering or direct dispensing of controlled substances, including by narcotic treatment programs (OTPs) or hospitals. **These policies are effective beginning March 31, 2020, and will remain in effect for the duration of the public health emergency, unless DEA specifies an earlier date.**

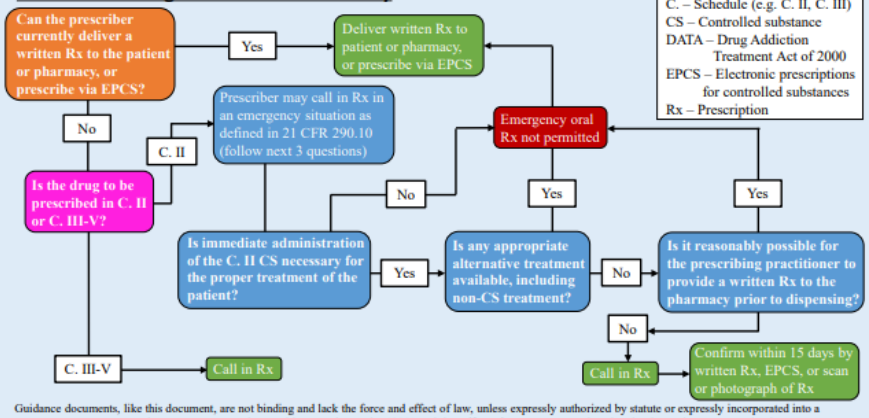
This decision tree merely summarizes the policies for quick reference and does not provide a complete description of all requirements. Full details are on DEA's COVID-19 website (https://www.deadiversion.usdoj.gov/coronavirus.html), and codified in relevant law and regulations.

Under federal law, all controlled substance prescriptions must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his/her professional practice. 21 CFR 1306.04(a). In all circumstances when prescribing a controlled substance, including those summarized below, the practitioner must use his/her sound judgment to determine that s/he has sufficient information to conclude that the issuance of the prescription is for a bona fide medical purpose. Practitioners must also comply with applicable state law.

Part I: Evaluating the Patient



Part II: Delivering the Rx to the Pharmacy



List of abbreviations:
C. – Schedule (e.g. C. II, C. III)
CS – Controlled substance
DATA – Drug Addiction Treatment Act of 2000
EPCS – Electronic prescriptions for controlled substances
Rx – Prescription

 Drug Enforcement Administration/Diversion Control Division

DEA075

https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf

U.S. DEPARTMENT OF JUSTICE ★ DRUG ENFORCEMENT ADMINISTRATION

DIVERSION CONTROL DIVISION

Use of Telemedicine While Providing Medication Assisted Treatment (MAT)

Under the Ryan Haight Act of 2008, where controlled substances are prescribed by means of the Internet, the general requirement is that the prescribing Practitioner must have conducted at least one in-person medical evaluation of the patient. U.S.C. § 829(e). However, the Act provides an exception to this requirement. 21 USC § 829 (e)(3)(A). Specifically, a DEA-registered Practitioner acting within the United States is **exempt** from the requirement of an in-person medical evaluation as a prerequisite to prescribing or otherwise dispensing controlled substances by means of the Internet **if** the Practitioner is engaged in the practice of telemedicine and is acting in accordance with the requirements of 21 U.S.C. § 802(54).

Under 21 U.S.C. § 802(54)(A),(B), for **most** (DEA-registered) Practitioners in the United States, **including** Qualifying Practitioners and Qualifying Other Practitioners ("Medication Assisted Treatment Providers"), who are using FDA approved Schedule III-V controlled substances to treat opioid addiction, the term "practice of telemedicine" means the practice of medicine in accordance with applicable Federal and State laws, by a practitioner (other than a pharmacist) who is at a location remote from the patient, and is communicating with the patient, or health

https://www.hhs.gov/opioids/sites/default/files/2018-09/hhs-telemedicine-dea-final-508compliant.pdf

U.S. Department of Health and Human Services

Telemedicine and Prescribing Buprenorphine for the Treatment of Opioid Use Disorder

September 2018

THE UNITED STATES is in the midst of an unprecedented crisis of prescription and illicit opioid misuse, addiction, and overdose. To combat the epidemic HHS is working to prevent more people from becoming addicted while also expanding access to treatment and recovery support services for those with opioid use disorder. Improving access to medication-assisted treatment (MAT) for opioid use disorder, which combines the use of medications (methadone, buprenorphine, and naltrexone) with psychosocial and other behavioral health support services, is a critical component of the HHS Opioid Strategy.

Despite the well-documented effectiveness of MAT, the majority of Americans with opioid use disorder do not receive this life-saving treatment. This is particularly true in some rural and remote areas of the country where there are few clinicians available to provide MAT and patients often have to travel long distances to receive care or go without care. One particular barrier to MAT access is the limited number of practitioners with a Drug Addiction Treatment Act of 2000 ("DATA 2000") waiver, which allows qualified practitioners to prescribe buprenorphine, for the treatment of opioid use disorder in settings other than a federally regulated opioid treatment program.

HHS remains committed to bringing the full extent of its resources to bear on the opioid crisis. Reflecting this commitment, the Department is working with the Drug Enforcement Administration (DEA) to

https://www.hhs.gov/opioids/sites/default/files/2018-09/hhs-telemedicine-hhs-statement-final-508compliant.pdf

Adjusting Drug Testing Protocols

This provides guidance to outpatient addiction treatment providers and programs (ASAM Levels 0.5, 1, 2.1, 2.5, OTP and OTS) regarding making adjustments to drug testing protocols to address the COVID-19 pandemic. The goal is to balance the utility of having the data from a urine drug test against the risk of COVID-19 virus exposure to patients, laboratory staff, and clinic staff/providers.

Please read our content disclaimer

Updated: 3/25/20

Topics:

1. Consider pausing urine drug testing in clinical practice +

2. Explore options for drug testing at a distance. +

3. Additional Resources +

Policy for Certain REMS Requirements During the COVID-19 Public Health Emergency

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Guidance for Industry and Health Care Professionals

I. Introduction

The Food and Drug Administration (FDA or Agency) plays a critical role in protecting the United States from threats including emerging infectious diseases, including the Coronavirus Disease 2019 (COVID-19) pandemic. FDA is committed to providing timely guidance to support response efforts to this pandemic.

FDA is issuing this guidance to communicate its temporary policy for certain risk evaluation and mitigation strategies (REMS) requirements for the duration of the public health emergency

https://www.fda.gov/media/136317/download

Newsroom
Coronavirus
COVID-19 Information for SAMHSA Discretionary Grant Recipients
Media Guidelines for Bullying Prevention
Press Announcements
SAMHSA in the News
Speeches and Presentations
Infographics
Logo Use Guidelines

Coronavirus (COVID-19)

SAMHSA recognizes the challenges posed by the current COVID-19 situation and is providing the following guidance and resources to assist individuals, providers, communities, and states across the country. SAMHSA stands ready to assist in any manner possible.

SAMHSA Resources and Information

NEW: COVID-19 Information for SAMHSA Discretionary Grant Recipients

COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance (PDF | 168 KB)

TAP 34: Disaster Planning Handbook for Behavioral Health Treatment Programs

NEW: Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic: March 20, 2020 (PDF | 76 KB)

NEW: Considerations for Crisis Centers and Clinicians in Managing the Treatment of Alcohol or

https://www.samhsa.gov/coronavirus

SAMHSA
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance

In response to the Novel Coronavirus Disease (COVID-19) pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) is providing this guidance to ensure that substance use disorder treatment services are uninterrupted during this public health emergency. SAMHSA understands that, in accordance with the Centers for Disease Control and Prevention guidelines on social distancing, as well as state or local government-issued bans or guidelines on gatherings of multiple people, many substance use disorder treatment provider offices are closed, or patients are not able to present for treatment services in person. Therefore, there has been an increased need for telehealth services, and in some areas without adequate telehealth technology, providers are offering telephonic consultations to patients. In such instances, providers may not be able to obtain written patient consent for disclosure of substance use disorder records.

The prohibitions on use and disclosure of patient identifying information under 42 C.F.R. Part 2 would not apply in these situations to the extent that, as determined by the provider(s), a medical emergency exists. Under 42 U.S.C. §290dd-2(b)(2)(A) and 42 C.F.R. §2.51, patient identifying information may be disclosed by a part 2 program or other lawful holder to medical personnel, without patient consent, to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained. Information disclosed to the medical personnel who are treating such a medical emergency may be re-disclosed by such personnel for treatment purposes as needed. We note that Part 2 requires programs to document certain information in their records after a disclosure is made pursuant to the medical emergency exception. **We emphasize that, under the medical emergency exception, providers make their own determinations whether a bona fide medical emergency exists for purposes of providing needed treatment to patients.**

https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf

AGENDA

- Introduction
- Legal hurdles
- Clinical hurdles
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- Other issues
  - Preparing for post-PHE
  - Malpractice insurance
  - “How to’s”

Preparing for What's Next - To Do List

JUNE 2020

NOTE: We are operating in uncharted territory and there are very few clear answers currently. This is a very fluid situation and the risk management recommendations below may change. This document will be updated on our FAQ page (www.PRMS.com/FAQ), and should be checked regularly. Nothing presented here is legal advice.

While we do not know exactly what will happen next in terms of the country re-emerging from the COVID-19 Public Health Emergency (PHE), psychiatrists should be prepared to address at least the following issues:

1. RE-OPENING YOUR PSYCHIATRIC OFFICE
In addition to your local community guidelines, review guidelines and best practices from the AMA, MGMA (Medical Group Management Association), CMS, and others.
***Tip**: Links to these resources are in our FAQs.*

2. FOR PATIENTS THAT REMAINED LOCAL, DETERMINE WHETHER THEY NEED TO BE SEEN IN-PERSON, REMOTELY, OR A COMBINATION OF BOTH
This determination should be based on your assessment of the patients' clinical needs, not on the patients' preference for telepsychiatry.

3. FOR PATIENTS CURRENTLY OUT-OF-STATE, DETERMINE IF THEY HAVE IMMINENT PLANS TO RETURN TO YOUR AREA
Manage patient expectations – let them know that the rules may be changing soon and you may not be allowed by law to continue to treat remotely.

4. TRACK STATE LICENSURE WAIVERS IN YOUR PATIENTS' STATES
They may expire on specific dates, or be extended, or withdrawn at any point.
***Tip**: PRMS will continue to track these licensure waivers in our FAQs.*

5. ONCE LICENSURE WAIVERS HAVE EXPIRED IN STATES WHERE YOUR PATIENTS ARE LOCATED, DETERMINE WHAT IS NEEDED TO CONTINUE TO TREAT YOUR PATIENT VIA TELEMEDICINE
States may require full licensure, a telemedicine registration, or there may be no requirements other than licensure in your own state to treat existing patents.
PRMS will help our insureds find this information.

6. IF AFTER THE WAIVER ENDS, YOU ARE ALLOWED TO CONTINUE TO SEE THE OUT-OF-STATE PATIENT, DETERMINE AND FOLLOW THAT STATE'S STANDARD TELEMEDICINE RULES THAT WILL LIKELY BE BACK IN EFFECT
States can have laws addressing requirements for in-person visits, informed consent, documentation, etc. If your patient's state does not have such laws, follow the telemedicine guidelines developed by the Federation of State Medical Boards.
PRMS will help our insureds find this state information.

7. IF AFTER THE WAIVER ENDS, YOU ARE NOT ABLE TO CONTINUE TREATING THE OUT-OF-STATE PATIENT (I.E. FULL LICENSURE IS REQUIRED), TERMINATE TREATMENT
Although this should be done quickly, do not abandon your patient– consider giving 30 days' notice.

8. IF AFTER THE WAIVER ENDS YOU WANT TO CONTINUE TREATING YOUR PATIENT REMOTELY AND HAVE DETERMINED THAT YOU ARE IN COMPLIANCE WITH LICENSING REQUIREMENTS, ENSURE YOU ARE ALSO IN COMPLIANCE WITH THE PATIENT'S STATE'S PRESCRIBING LAWS
There may be specific state laws, particularly for controlled substances.
You should also register with and use, to the extent possible, the state prescribing drug monitoring program.

9. IF YOU ARE PRESCRIBING CONTROLLED SUBSTANCES FOR OUT-OF-STATE PATIENTS, BE ALERT TO WHEN HHS DECLARES THE END TO THE PHE
The current PHE declaration is set to expire near the end of July. It can be revoked earlier, or extended.
***Tip**: PRMS will be tracking this in our FAQs.*
When the PHE ends, two currently suspended federal requirements for prescribing controlled substances will likely go back into effect.
First, the requirement that there be an in-person visit prior to prescribing controlled substances will likely go back into effect. It is unclear whether the DEA will require those who began treating patients during the PHE to have an in-person visit after the PHE expires in order to continue prescribing controlled substances to these patients.
Second, the requirement to have a federal DEA registration in the patient's state (as well as in your state) will likely go back into effect.

10. WHEN THE PHE ENDS, EXPECT HHS TO REINSTATE THE REQUIREMENT THAT TELEMEDICINE MUST BE CONDUCTED VIA A HIPAA-COMPLIANT PLATFORM
This generally means that you will need a Business Associate Agreement (BAA) from the vendor.

For additional information, see our Telepsychiatry Checklist at PRMS.com/FAQ

MEDICAL MALPRACTICE INSURANCE

- Not all carriers cover telemedicine
- Some carriers will only cover telemedicine if specific conditions are met
  - Ex: only cover if patient is in physician's state
  - Ex: only consultation, not treatment
  - Ex: only cover in desirable jurisdictions
- Not all carriers will cover services rendered out of state
  - May not be set up to defend in patient's state
- Some carriers may have premium surcharge for telemedicine
  - Ex: if patients are in a state without damage caps
- ASK:
  - Does carrier cover telemedicine?
  - Are there any restrictions?
  - Are there any requirements?
  - Is there a surcharge?
  - Is there coverage for suits brought out of state?
- Resource: www.cchpca.or/gtelehealth-policy/malpractice

MARYLAND HEALTH CARE COMMISSION

Telehealth Professional Liability Insurance

Providing Telehealth Services across State Lines

Providers who practice telehealth across State lines may experience barriers with liability coverage. Carriers who are licensed to provide liability coverage in a limited number of states are not able to cover telehealth services rendered in a state in which they are not licensed.[3]

[3] In Maryland, Medical Mutual, the top liability insurance provider, is only licensed to cover physicians practicing in Maryland, the District of Columbia, or Virginia, and can only cover telehealth if the patient and the provider are located in one of those three locations.

Maryland Health Care Commission, March 2018

mhcc.maryland.gov
Accessed June 12, 2020

“HOW TO” REMINDERS

Before the encounter

- Equipment
- Clinical information
- Dress
- Noise and privacy
- Background and lighting
- Cultural competence

“HOW TO” REMINDERS

During the encounter

- Introductions
- Consent
- Framing
- Comfort
- Silence device and microphones (until the session starts)
- Encourage questions

NO YELLING!!!

“HOW TO” REMINDERS

After the encounter

- Follow-up appointments noted
- Technical issues reported to appropriate support personnel

PUBLIC HEALTH

Helping private practices navigate non-essential care during COVID-19

Private practice physicians are currently facing new and unfamiliar challenges in safely delivering care to non-urgent patients. New for many practices is having to consider current and future needs for clinician services, the supply of laboratory test kits and access to personal protective equipment (PPE).

The Centers for Disease Control and Prevention (CDC) recommends that health care facilities and clinicians prioritize urgent and emergency visits and procedures now and for the coming several weeks.

The following actions can preserve staff, PPE, patient care supplies, ensure staff and patient safety and expand available hospital capacity during the COVID-19 pandemic:

- Delay all elective ambulatory provider visits
- Reschedule elective and non-urgent admissions
- Delay inpatient and outpatient elective surgical and procedural cases
- Postpone routine dental and eyecare visits
- Tools and resources exist as part of healthcare system preparedness plans and are often referred to as Pandemic Plans. Consult your state or local health department about specific plans for your community.

The Centers for Medicare and Medicaid Services (CMS) has also issued guidance limiting all non-essential planned surgeries and procedures, including dental, until further notice. CMS has also released a COVID-19 Partner Toolkit with guidance for physicians and their teams working with various populations.

Recommendations:

Essential Tools & Resources

- Featured updates: COVID-19 resource center
- COVID-19 caregiver resources
- COVID-19 FAQ: Your pressing questions answered
- Your guide to COVID-19 preparedness
- AMA quick-start telemedicine guide

https://www.ama-assn.org/delivering-care/public-health/helping-private-practices-navigate-non-essential-care-during-covid-19

DIGITAL

AMA quick guide to telemedicine in practice

In an effort to keep our health care workers and patients safe amid the COVID-19 pandemic, the American Medical Association (AMA) has designed this quick guide to support physicians and practices in expediting the implementation of telemedicine, so care can continue to be provided to those who need it most.

Practice implementation | Policy, coding & payment | Other helpful resources

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Telemedicine spans a continuum of technologies that offer new ways to deliver care including:

– Real-time, audio-video communication tools (telehealth) that connect physicians and patients in different locations.

– Store-and-forward technologies that collect images and data to be transmitted and interpreted later.

– Remote patient-monitoring tools such as blood pressure monitors, Bluetooth-enabled digital scales and other wearable devices that can communicate biometric data for review (which may involve the use of mHealth apps).

– Verbal/audio-only and virtual check-ins via patient portals, messaging technologies, etc.

If you are planning to implement telehealth (real-time audio/visual visits between you and your patients) into your practice for the first time, below are some key considerations:

Getting Started

– Set up a team that will help facilitate the expedited implementation of telemedicine services and be able to make decisions quickly to ensure launch as soon as possible.

– Check with your malpractice insurance carrier to ensure your policy covers providing care via telemedicine.

– Familiarize yourself with payment and policy guidelines specific to various telemedicine services.

Vendor evaluation, selection & contracting

– Check with your existing EHR vendor to see if there is telehealth functionality that can be turned on.

Essential Tools & Resources

A Physician's Guide to COVID-19

COVID-19 FAQ: Your pressing questions answered

AMA president speaks on preparing physicians for COVID-19

JAMA Network: Coronavirus disease 2019 (COVID-19)

CDC monitoring of COVID-19 outbreak

https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice

APA Coronavirus Resources

To provide support in the response to the novel coronavirus (COVID-19), APA is collecting authoritative and timely resources in this information hub.

If you are a patient or family member or friend in need of immediate assistance:

- **Disaster Distress Helpline**
  Call 1-800-985-5990 or text TalkWithUs to 66746
- **National Suicide Prevention Lifeline**
  Call 800-273-8255 or Chat with Lifeline

https://www.psychiatry.org/psychiatrists/covid-19-coronavirus

Practice Guidance for COVID-19

Updated March 23, 2020

Below is guidance released by the Department of Health and Human Services, FDA and at the state level related to COVID-19 to assist psychiatrists with providing mental health and substance use services.

Click on a topic below to jump to the relevant practice guidance:

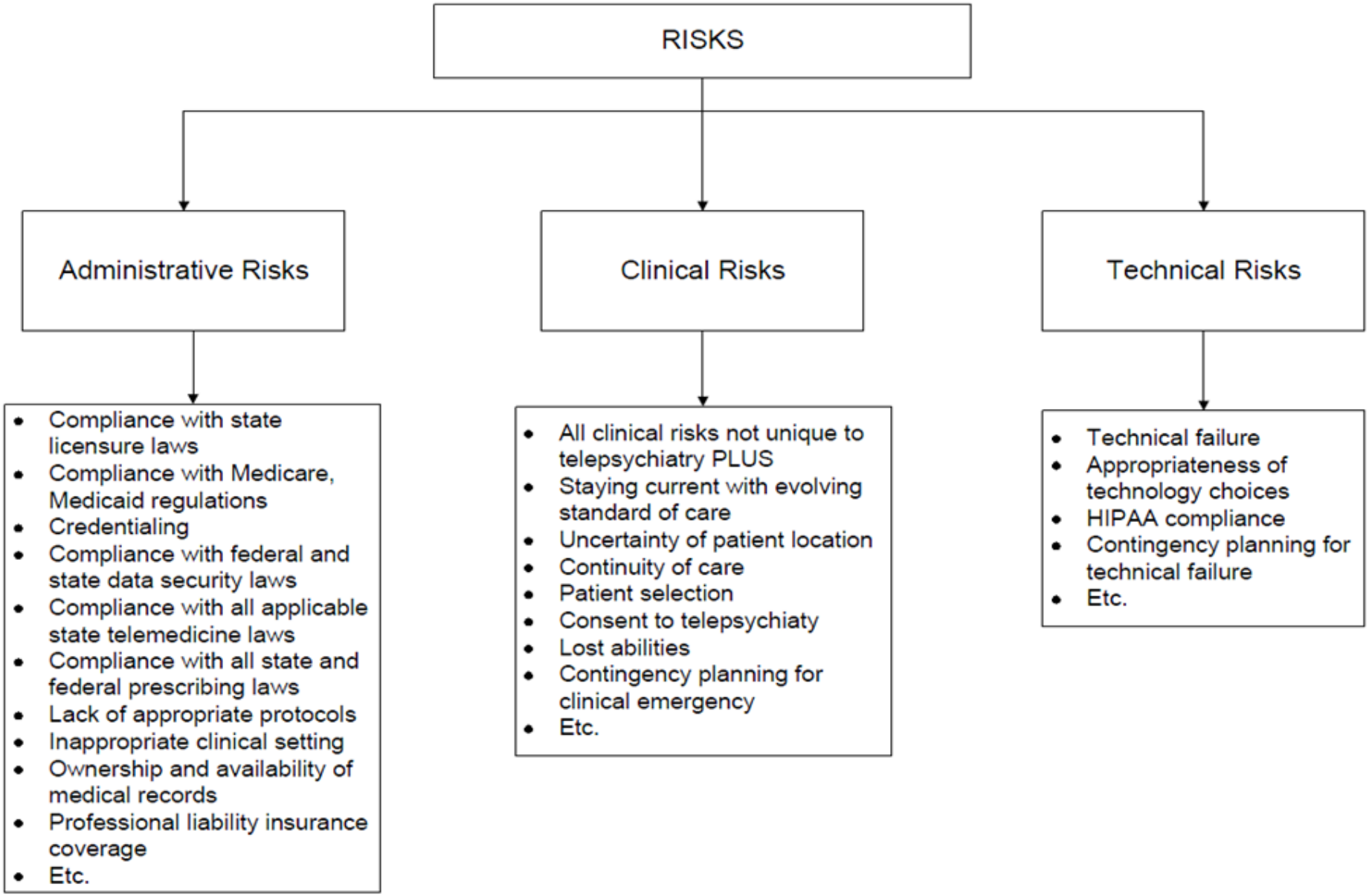
[Telehealth] [Substance Use Disorders] [Inpatient Psychiatric Settings] [Commercial Payers] [State-by-State Guide]

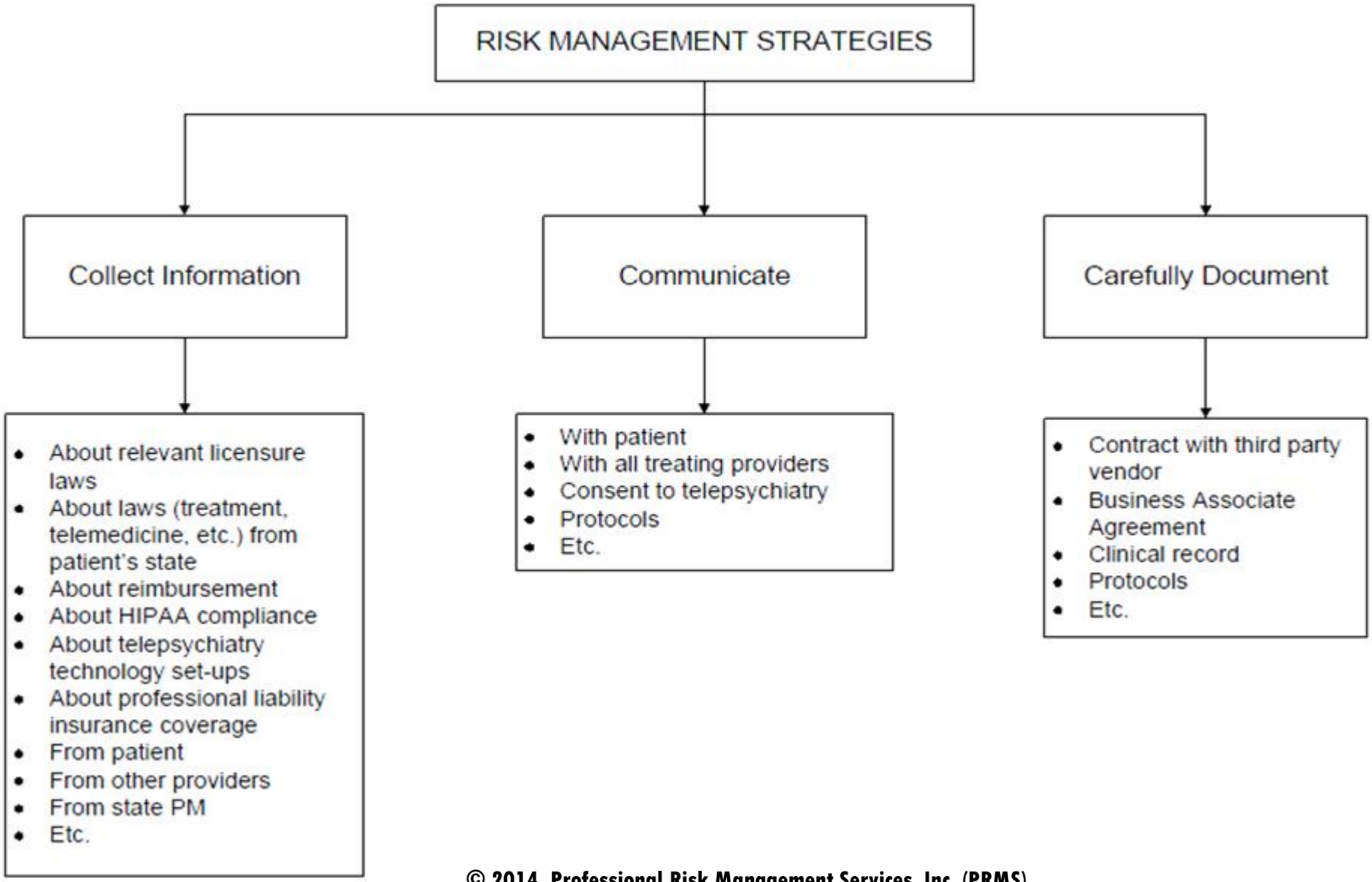
General

- **REMS**: On March 23, the Food and Drug Administration released guidance to sponsors and healthcare providers regarding certain Risk Evaluation and Mitigation Strategy (REMS). For drugs subject to REMS with laboratory testing (or imaging) requirements (includes Clozapine), healthcare providers prescribing and/or dispensing these drugs should consider whether there are compelling reasons not to complete lab tests, or delay them, during this public health emergency and use best medical judgement in weighing the benefits and risks of continuing treatment in the absence of laboratory testing. The judgement regarding the risk/benefits should be communicated to patients. The FDA does not intend to take action against sponsors and other health care providers for the duration of the public health emergency for failing to adhere to REMS requirements for certain laboratory testing.
- **Medicare Quality Reporting**: CMS announced it is granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs. For those programs with data submission deadlines in April and May 2020, submission of those data will be optional, based on the facility's choice to report. In addition, no data reflecting services provided January 1, 2020 through June 30, 2020 will be used in CMS's calculations for the Medicare quality reporting and value-based purchasing programs.

Telehealth

https://www.psychiatry.org/psychiatrists/covid-19-coronavirus/practice-guidance-for-covid-19





FINAL COMMENTS

- PRMS resources available to all
  - FAQs (www.prms.com/faq)
    - Telepsych checklist
    - State waiver info
    - Preparing for what's next

- Additional resources available to those insured through PRMS
  - RMCS: one-on-one consultation with Risk Managers
  - Post-PHE state-specific telemedicine information

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