TELEPSYCHIATRY – MANAGING THE MAYHEM

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Professional Risk Management Services (PRMS)

Florida Psychiatric Society
October 1, 2021

ICNS INNOVATIONS IN CLINICAL NEUROSCIENCE
Peer-reviewed,evidence-based information for clinicians and researchers in the field of neurotherapeutics

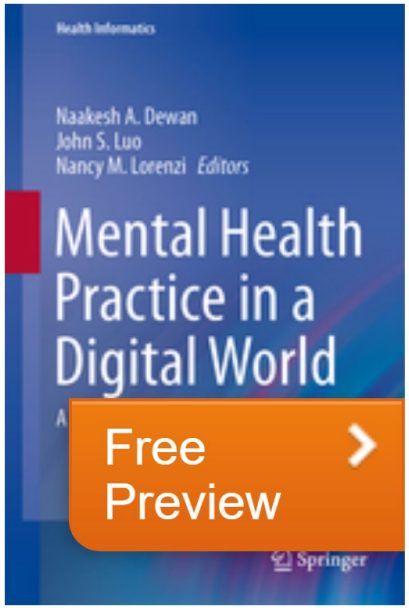
Top 10 Myths about Telepsychiatry

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 envi
which psychiatrists practice telepsychiatry is also evolving but at a much slowe
technology. As introduced in this journal years ago by my colleague Charles D.
article, "Telepsychiatry and Risk Management,"[1] there is still a lack of uniformi
even whether—states address telemedicine requirements. This discrepancy ha
many myths around this topic. Fortunately, we are starting to see some concep
are generally consistent, regardless of the state, allowing us to clear up some p
misunderstandings about telepsychiatry.



Chapter 8
An Overview of Practicing High Quality Telepsychiatry

Donna Vanderpool

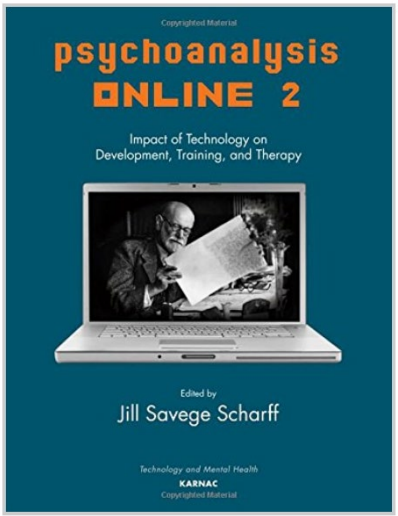
Abstract Providing psychiatric services remotely via telepsychiatry can be an effective care delivery model. Given the increasing need for psychiatric services, utilization of telepsychiatry is expected to increase for both consultation and treatment purposes. There are currently regulatory constraints, 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

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:

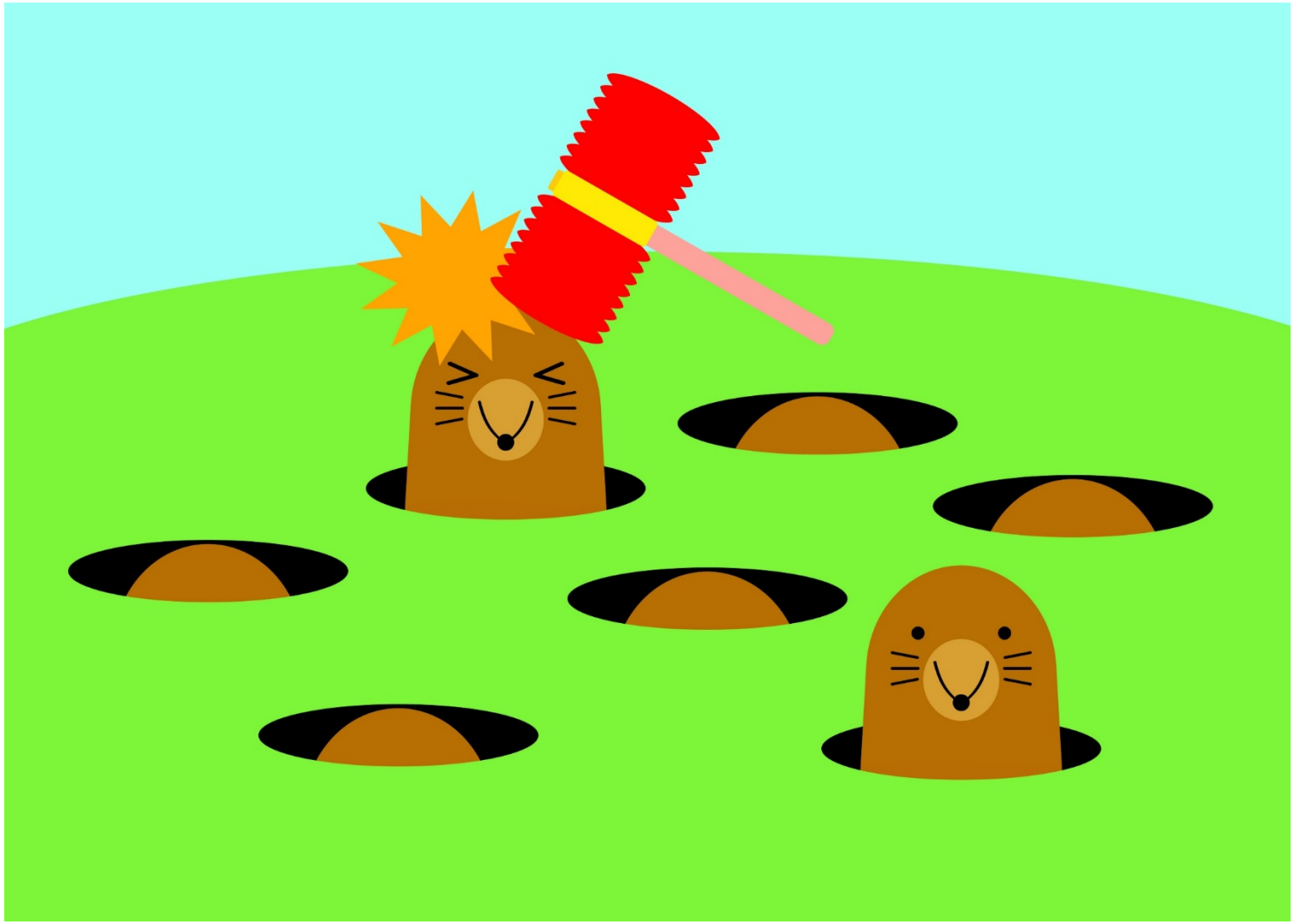
1. If the patient is in a different state than the provider, and the provider is not licensed in the patient's state, the patient's state licensing board should be contacted to determine whether licensure in the patient's state is required. While almost all states require some type of licensure or registration, 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.



Ms. Vanderpool has no financial relationships with commercial interests to disclose

DISCLAIMERS

- Nothing presented here is legal advice
- There is little consistency in how states are addressing telemedicine
- Things can change daily
  - Federal regulators are relaxing requirements
  - State regulators are relaxing requirements, then undoing the relaxations, then re-relaxing some
- What is true today may not be true tomorrow



LEARNING OBJECTIVES

At the conclusion of this program, attendees will be able to:

- Understand the various regulatory and clinical risks associated with telepsychiatry
- Distinguish between federal and state telemedicine waivers
- Discuss potential liability exposure once the telemedicine waivers expire

MY GOALS

- Share as many risks and risk management strategies as I can
- To help you decide how to you want to manage these risks
  - Risk tolerance
- And….hope you remember that I’m just the messenger!!

"JUST" 8 ISSUES!

- 3 Major:
  - State licensure (state)
  - Standard of care (state)
  - Prescribing controlled substances (state + federal)
- 5 Minor:
  - HIPAA (state + federal)
  - Consent (state)
  - Documentation (state)
  - Follow-up care / monitoring (state)
  - Contingency planning (state)

NOT COVERING

- Billing issues, except:
  - Medicare waivers for state licensure only relate to payment – not your ability to legally practice in a state
  - Payers – including Medicare and Medicaid may have in-person visit requirements separate from DEA and state requirements
- Vacation coverage
  - Licensing boards do not consider a contact with a patient vacationing in its state to be telemedicine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MAJOR ISSUE #1: STATE LICENSURE (BEFORE COVID EMERGENCY)

- Issue since 2006 (*Hageseth* case)
  - CA asserted jurisdiction over physician in CO who prescribed antidepressant to patient in CA
    - Criminal conviction and civil suit
  - Results:
    - Physician services rendered via telemedicine are deemed to take place where patient is located
    - Patient's state has jurisdiction over unlicensed physicians treatment patients in its state
    - Need to comply with laws (including re: licensure) in patient's state AND laws in physician's state

BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE STATE MEDICAL BOARD

In the Matter of the Application of	)	
	)	
SCOTT EMERY, M.D.	)	OAH No. 07-0169-MED
	)	Board Case No. 2801-05-003
	)	

DECISION AND ORDER

I. Introduction

Dr. Scott Emery ("Respondent") is a neurologist licensed to practice medicine in the states of Colorado and Oregon. Dr. Emery submitted an application for licensure in Alaska on June 24, 2005; he was issued a temporary license on August 9, 2005. The temporary license expired on February 9, 2006.

The Alaska State Medical Board ("Board") notified Dr. Emery by letter dated March 5, 2007 that his application for a license was denied by the Board because he practiced medicine while unlicensed by the State of Alaska when he performed an independent medical evaluation ("IME") on February 7, 2005 in Alaska.[1]

Dr. Emery filed his appeal of the Board's decision on March 27, 2007 and requested an administrative hearing. The formal hearing convened on July 23, 2007 before Administrative Law Judge ("ALJ") James T. Stanley. The Division of Corporations, Business, and Professional Licensing ("Division") called two witnesses to testify: Leslie A. Gallant, Executive Administrator, Alaska State Medical Board; and, Brian Howes, investigator for the Division. Dr. Emery testified and called two witnesses to testify: Nelson Page, attorney; and Roger Holmes, attorney. Division exhibits A, B, C, D and E were admitted into evidence.[2] Respondent exhibits 1-5, 9, 15, 17, 21-25, 28, and 30-32 were admitted into evidence. The hearing was recorded.

MAJOR ISSUE #1: STATE LICENSURE (BEFORE COVID EMERGENCY)

- Need to ensure state licensure requirements are met
- Risk = unauthorized practice of medicine
- Always an issue since *Hageseth*
  - Not recognized
- Possible consequences of unauthorized practice of medicine:
  - No professional liability insurance coverage
  - Investigation and discipline by state(s) where licensed

MAJOR ISSUE #1: STATE LICENSURE (BEFORE COVID EMERGENCY)

- Problem = no consistency
  - States didn't address telemedicine
  - If addressed, not uniformly
  - Very few states offered something less than full licensure, such as telemedicine registration (FL)
- Some states had licensure exceptions pre-COVID

Department of Health
Medical Quality Assurance Commission

Policy Statement

Title:	Telemedicine and Continuity of Care	POL2018-01
References:	RCW 18.71.030, RCW 18.71.230, chapter 18.71A RCW, RCW 18.71.011, Guideline MD2014-03	
Contact:	Medical Quality Assurance Commission	
Phone:	(360) 236-2750	E-mail: medical.commission@doh.wa.gov
Effective Date:	March 2, 2018	
Approved By:	Warren Howe, MD, Chair (signature on file)	

Policy

The Medical Quality Assurance Commission (Commission) supports the use of telemedicine as a tool that has the potential to increase access, lower costs, and improve the quality of healthcare. Because of rapid changes in telemedicine technology, the practice of medicine is occurring more frequently across state lines, raising regulatory challenges for state medical boards. The Commission issues this policy statement on the role of telemedicine to promote and facilitate continuity of care.

The Commission interprets current law to permit, under certain circumstances, non-Washington-licensed practitioners to use telemedicine to provide follow-up care to established patients in Washington. The Commission also interprets current law to allow Washington-licensed practitioners to use telemedicine to consult with non-Washington-licensed practitioners in other states. This policy statement is consistent with current law, and strikes the appropriate balance between enhancing access to care and ensuring patient safety.

https://wmc.wa.gov/sites/default/files/public/documents/TelemedicineAndContinuityOfCarePOL2018-01.pdf

(2) Exemptions. Exemptions to the practice of medicine or osteopathy across state lines are defined as follows:

(a) A physician who engages in the practice of medicine across state lines in a medical emergency, as defined in these rules, is not subject to the provisions of 97-166 Ala. Acts;

(b) A physician who engages in the practice of medicine or osteopathy across state lines on an irregular or infrequent basis, as defined in these rules, is not subject to the provisions of 97-166 Ala. Acts.

(3) Medical Emergency. A medical emergency is a condition or circumstance that, in the best clinical judgment of the attending physician on the facts before him or her, so compromises the health, safety or well-being of the patient as to require immediate treatment.

(4) Irregular or Infrequent. The irregular or infrequent practice of medicine across state lines is deemed to occur if such practice occurs less than ten (10) times in a calendar year or involves fewer than ten (10) patients in a calendar year or comprises less than one percent (1%) of the physician's diagnostic or therapeutic practice.

MAJOR ISSUE #1: STATE LICENSURE (DURING COVID EMERGENCY)

- Most states enacted some type of licensure waiver, but no consistency
  - Just applied to physicians physically coming into state
  - Required temporary license
  - Required just notification to board
  - Did not allow prescribing CS
  - Nothing required

MAJOR ISSUE #1: STATE LICENSURE (DURING COVID EMERGENCY)

- Currently most waivers have expired
  - Some retroactively!
  - Some expired, but have gone back into effect

CAUTION!

- If a state expires its State of Emergency, waivers enacted under that SoE expire
- Some states (FL) rely on federal law for the in-person visit prior to prescribing CS
- Alert: Some states require in-person visit prior to prescribing CS
  - Separate from federal requirement (RHA)
  - In these states, if the state waiver expires prior to federal waiver, need to follow state law
    - Start seeing patients prior to prescribing CS

MAJOR ISSUE #1: STATE LICENSURE (DURING COVID EMERGENCY)

- Problem = confusion over “licensure waivers”

Waiver of licensure by PAYMENT regulator

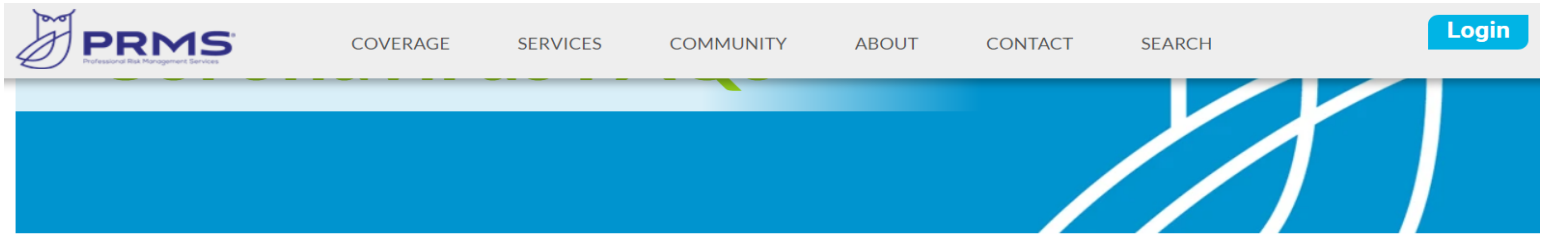
≠

Waiver of licensure by LICENSURE regulator

MAJOR ISSUE #1: STATE LICENSURE (DURING COVID EMERGENCY)

- Problem = keeping track of patients
  - Patients have scattered all over the world
  - Solution: confirm patient's location at the beginning of every telepsych session
    - Patient safety
    - Licensure compliance

- Problem = keeping track of state waivers
  - www.prms.com/faq



UPDATED: September 1, 2021

NOTE: Please remember that we are all operating in uncharted territory and there are very few clear answers. If you are insured through PRMS, watch for more details about "Let's Talk" - a new resource providing more in-depth risk management thoughts on your many questions without answers.

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
- Seeing Patients in Your Office **(Added 8/30/21)**
- Five Things to Know About the Ryan Haight Act **(Added 7/28/21)**
- Preliminary Analysis Chart to determine if state licensure is relevant **(Added 1/14/21)**
- Preparing For What's Next - To Do List **(Updated 7/2/21)**
- State Guidelines For Re-Opening a Medical Office **(Updated 3/30/21)**
- Telepsychiatry and COVID-19: What We Do and Do Not Know On-Demand Tutorial
- Telepsychiatry Checklist **(Updated 8/30/21)**
- Telepsychiatry: Keeping Up With Your Regulators' Waivers **(Added 2/19/21)**

Online Courses

PRMS® clients can log into PRMS U to access a wide variety of CME and non-CME courses on many relevant topics.

ACCESS PRMS U

HIPAA HELP

Do You Know Enough About HIPAA?

To help you learn how HIPAA affects you and your practice, The Psychiatrists' Program offers a HIPAA Help checklist to make you more familiar with these regulations.

VIEW HIPAA HELP

http://www.prms.com/services/risk-management/coronavirus-faqs/

Press Releases

STATE OF CONNECTICUT

GOVERNOR NED LAMONT

05/10/2021

Governor Lamont Signs Legislation Extending Telehealth Services for Another Two Years

Click image to download in high quality

(HARTFORD, CT) – Governor Ned Lamont today announced that he has signed into law legislation that extends for another two years the relaxed telehealth services provisions that he previously enacted through an emergency executive order due to the COVID-19 pandemic.

Telehealth services are those that enable healthcare providers to interact with patients, including those with Medicaid coverage, by using electronic methods, such as videoconferencing and telephones, without needing to meet in person.

https://portal.ct.gov/Office-of-the-Governor/News/Press-Releases/2021/05-2021/Governor-Lamont-Signs-Legislation-Extending-Telehealth-Services-for-Another-Two-Years

MAJOR ISSUE #1: STATE LICENSURE (AFTER COVID EMERGENCY)

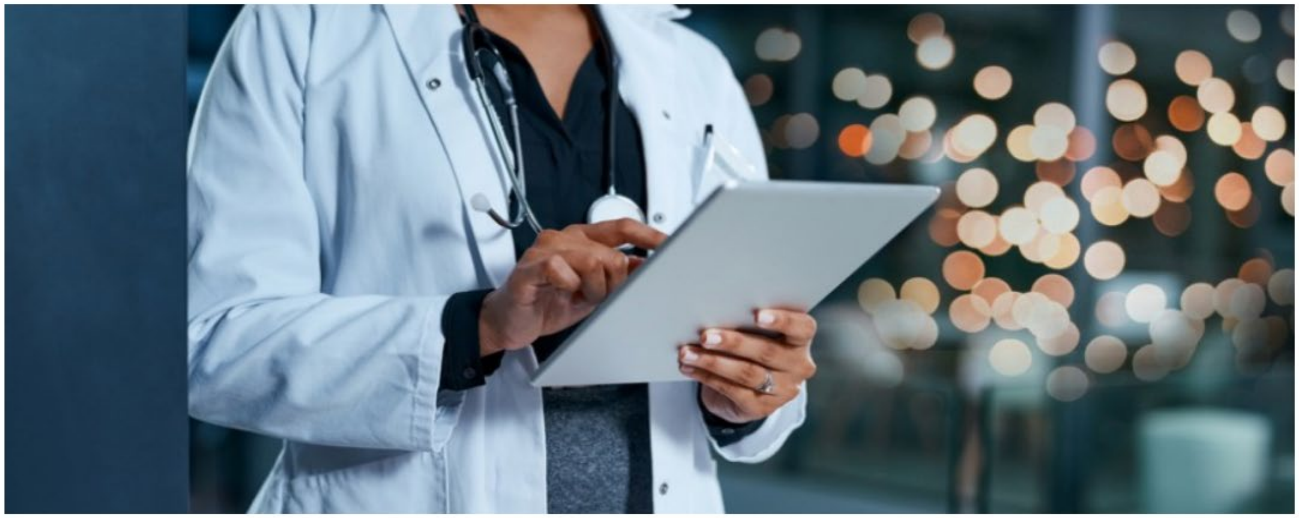
If patients are in states with expired licensure waiver:

- Option #1 – wing it and hope no consequences
  - Understand the known risk
  - Additional risk is possible

A Target on Telehealth: Government Action Against Telehealth Fraud in the Wake of COVID-19

15 July 2021 | Health Care Law Today | Blog

Authors: Kyle Y. Faget, Lisa M. Noller, Lori A. Rubin, Lauren P. Carboni, Olivia R. King



The COVID-19 Public Health Emergency (PHE) is expected to prompt unprecedented levels of regulatory enforcement activity that is focused on the use of telemedicine. In fact, fraudulent and abusive telehealth practices was an area identified by the Department of Justice (DOJ) as an enforcement priority even prior to the COVID-19 PHE. Telehealth has

https://www.foley.com/en/insights/publications/2021/07/target-on-telehealth-government-action-fraud

6. Continuing to Operate Under COVID-19 Temporary Waivers

The COVID-19 PHE waivers put in place by HHS and other federal and state authorities are largely temporary and set to expire upon the end of the PHE. However, many provider and health systems have relied heavily on these temporary waivers and may have difficulty scaling back their reliance.

For instance, some states waived certain licensure requirements to improve the states' ability to provide care to COVID-19 patients. A survey conducted by the Federation of State Medical Boards reports that as of June 23, 2021, 26 states have waivers in place modifying telehealth requirements including allowing telehealth practice by out-of-state physicians and audio-only communication, or waiving the requirement that there be a preexisting provider-patient relationship.[20] We predict some out-of-state providers may face sanctions from state licensing boards related to continued practice via telehealth after the temporary licensure waivers expire.

Providers may also have difficulty rolling back reliance on waivers issued by HHS that exempt certain types of remuneration and referral arrangements from sanctions under the physician self-referral (Stark) law. For instance, under the Blanket Waivers, HHS exempted the following arrangements (among others) from sanctions under Stark (provided the remuneration and referrals are solely related to a COVID-19 purpose), both of which without this temporary waiver would constitute a technical violation of the Stark:

- Remuneration from an entity to a physician that is above or below fair market value for services personally performed by the physician; and
- Referral by a physician of a Medicare patient to a home health agency in which the physician has an ownership interest.[21]

Providers may have difficulty quickly bringing their operations into compliance once the temporary waivers expire, which may expose providers to state and federal sanctions, including liability under the False Claims Act. Reliance on these temporary COVID-19 waivers past the termination of the PHE may present an easy opportunity for government enforcement.

MAJOR ISSUE #1: STATE LICENSURE (AFTER COVID EMERGENCY)

If patients are in states with expired licensure waiver:

- Option #2 – determine if you can continue treating patient in state where you are not licensed
  - Initial research
    - Your Risk Managers
    - CCHP (www.cchpca.org)
    - Epstein, Becker & Green app (www.eglaw.com/telemental-health-laws-app)

CCHP

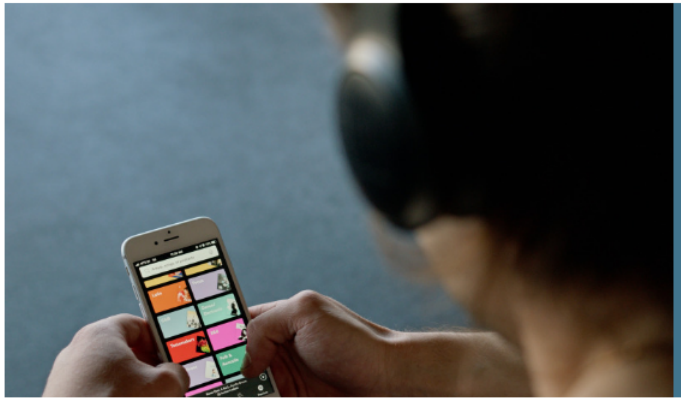
Look up policy by: Topic | Federal | State

CCHP is the National Telehealth Policy Resource Center

The Center for Connected Health Policy is a nonprofit, nonpartisan organization working to maximize telehealth's ability to improve health outcomes, care delivery, and cost effectiveness. Our expertise in telehealth policy was recognized in 2012, when we became the federally designated National Telehealth Policy Resource Center.

LEARN MORE ABOUT OUR WORK

https://www.cchpca.org/



Download Epstein Becker Green's Telemental Health Laws App

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Since 2016, Epstein Becker Green has researched, compiled, and analyzed state-specific content relating to the regulatory requirements for professional mental/behavioral health practitioners and stakeholders seeking to provide telehealth-focused services. We are pleased to release our latest and most comprehensive compilation of state telehealth laws, regulations, and policies within the mental/behavioral health practice disciplines. And for the first time, in response to reader requests, we have added content specific to the provision of telehealth services in Puerto Rico.

While other state-focused telehealth surveys exist, this survey focuses solely on the remote delivery of *behavioral* health care services. With changes rapidly taking place, it is vital to keep this important resource up to date as the legal and regulatory landscape continues to evolve.

https://www.ebglaw.com/telemental-health-laws-app/

MAJOR ISSUE #1: STATE LICENSURE (AFTER COVID EMERGENCY)

If patients are in states with expired licensure waiver:

- Option #2 – determine if you can continue treating patient in state where you are not licensed
  - Initial research
  - Contact licensing board to either verify an exception or confirm license is actually needed, stressing:
    - Existing patient
    - Board certification(s)
    - If only for a limited time
    - If not prescribing CS, or any meds

CAUTION!

Even if you get permission from licensing board in patient's state to treat without a license there, you still may not be able to prescribing CS

- Clarify with board

MAJOR ISSUE #1: STATE LICENSURE (AFTER COVID EMERGENCY)

Donna's predictions:

- No universal medical license covering all states
- More special telemedicine licenses / registrations
- More coordination between states
  - Border jurisdictions
  - Regions

MAJOR ISSUE #1: STATE LICENSURE (AFTER COVID EMERGENCY)

Donna's predictions:

- More guidance from licensing boards on licensure exceptions
- More confusion over "licensure waivers"

Calendar Year (CY) 2022 Medicare Physician Fee Schedule Proposed Rule

CMS is proposing to require an in-person, non-telehealth service be provided by the physician or practitioner furnishing mental health telehealth services within six months prior to the initial telehealth service, and at least once every six months thereafter. We are seeking comment on whether a different interval may be necessary or appropriate for mental health services furnished through audio-only communication technology. We are also seeking comment on how to address scenarios where a physician or practitioner of the same specialty/subspecialty in the same group may need to furnish a mental health service due to unavailability of the beneficiary's regular practitioner.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-proposed-rule

MAJOR ISSUE #1: STATE LICENSURE (AFTER COVID EMERGENCY)

If patients are in states with expired licensure waiver:

- Option #1 – wing it and hope no consequences
  - Understand the known risk
  - Additional risk is possible

MAJOR ISSUE #1: STATE LICENSURE (AFTER COVID EMERGENCY)

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Insurance
Policy

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

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

MAJOR ISSUE #2: STANDARD OF CARE (BEFORE COVID EMERGENCY)

- SOC ≠ optimal care
  - Continuum; two ends:
    - Barely competent care – all that's needed legally
    - Ultimate care – strive towards this end clinically
- Failure to meet SOC = negligence
  - Negligence is just one of 4 elements ∏ has to prove
    - Other 3: duty, harm, causation
- SOC changes – especially for telemedicine
  - New research
  - New technology
- Physician discretion and clinical judgment are important
  - Needs to be documented in record so treatment can be understood

MAJOR ISSUE #2: STANDARD OF CARE (BEFORE COVID EMERGENCY)

- Is the same standard of care that would apply if the patient was physically in the physician's office or facility
- Many states have explicitly addressed
  - By statute
    - Ex: FL 766.201

      "The prevailing professional standard of care shall be that level of care, skill, and treatment which, in light of all relevant surroundings circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers."
  - By licensing board position statement

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.

The Medical Board cautions, however, that licensees practicing via telemedicine will be held to the same standards of care as licensees employing more traditional in-person medical care. A failure to conform to appropriate standards of care whether that care is rendered in-person or via telemedicine may

FACTORS THAT *MAY* EVIDENCE THE TELEMEDICINE STANDARD OF CARE

- Statutes – federal and state
  - The Controlled Substances Act, as amended by Ryan Haight Act
  - States can address in-person visits, termination, prescribing, reporting abuse, etc.
    - NH Rev Stat § 329:1-d discusses when in-person visit is required prior to prescribing AND when annual in-person visit is needed

- Regulations – federal and state
  - HIPAA's Privacy and Security Rules
  - Iowa Admin. Code § 653-13.11 says HIPAA must be complied with when delivering telemedicine services

FACTORS THAT *MAY* EVIDENCE THE TELEMEDICINE STANDARD OF CARE

- Court opinions – federal and state
  - *Hageseth v. Superior Court* (CA App. 2007): services deemed rendered in patient's state and patient's state has jurisdiction over out-of-state provider
- Other regulatory materials – federal and state
  - North Carolina Medical Board *Position Statement on Telemedicine*
- Authoritative clinical guidelines
  - AACAP *Practice Parameter for Telepsychiatry with Children and Adolescents*
    - *+ 2017 Clinical Update*

FACTORS THAT *MAY* EVIDENCE THE TELEMEDICINE STANDARD OF CARE

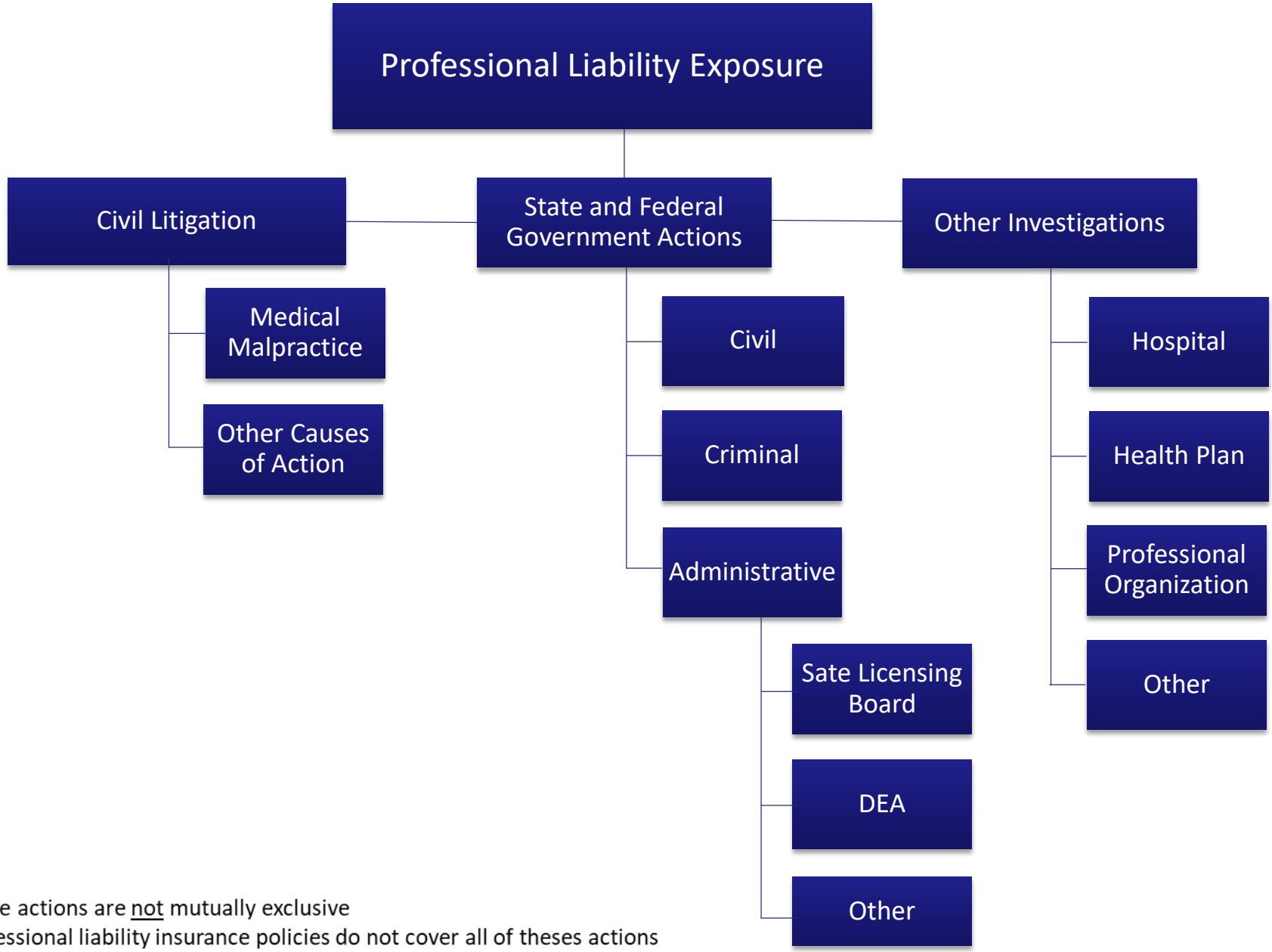
- Policies and guidelines from professional organizations
  - APA and ATA *Best Practices in Videoconferencing-Based Telemental Health*
  - AMA Ethics Opinion 1.2.12 *Ethical Practice in Telemedicine*
  - FSMB *Model Policies for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*
- Journal / research articles
  - Hubley S et al. Review of key telepsychiatry outcomes. World J Psychiatry. 2016 Jun 22;6(2):269-82
- Accreditation standards
  - Joint Commission Telemedicine Standards; FAQ on telemedicine and restraints and seclusion
- Facility policies and procedures
- …

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

The American Psychiatric Association

and

The American Telemedicine Association



Notes:

* These actions are not mutually exclusive
* Professional liability insurance policies do not cover all of theses actions

MAJOR ISSUE #2: STANDARD OF CARE (DURING COVID EMERGENCY)

- Some state requirements may have been waived
  - Ex: in-person visit requirement
- Patients reluctant to get necessary testing
- No “disaster standard of care”

MAJOR ISSUE #2: STANDARD OF CARE (AFTER COVID EMERGENCY)

- States that waived certain telemedicine requirements will put those requirements back into effect
- Those requirements back into effect will need to be complied with

MAJOR ISSUE #3: PRESCRIBING CS – STATE LAW (BEFORE COVID EMERGENCY)

- States had various restrictions
  - Not allowing CS to be prescribed via telemedicine
  - Limits on when CS can be prescribed via telemedicine
    - ex: FL
  - Requiring in-person visit prior to prescribing CS via telemedicine
  - Requiring subsequent in-person visits when prescribing CS via telemedicine

NEW JERSEY STAT. 45:1-62: USE OF TELEMEDICINE AND TELEHEALTH BY HEALTH CARE PROVIDERS; REQUIREMENTS

e. The prescription of Schedule II controlled dangerous substances through the use of telemedicine or telehealth shall be authorized only after an initial in-person examination of the patient, as provided by regulation, **and a subsequent in-person visit with the patient shall be required every three months for the duration of time that the patient is being prescribed the Schedule II controlled dangerous substance.** However, the provisions of this subsection shall not apply, and the in-person examination or review of a patient shall not be required, when a health care provider is prescribing a stimulant which is a Schedule II controlled dangerous substance for use by a minor patient under the age of 18, provided that the health care provider is using interactive, real-time, two-way audio and video technologies when treating the patient and the health care provider has first obtained written consent for the waiver of these in-person examination requirements from the minor patient's parent or guardian.

MAJOR ISSUE #3: PRESCRIBING CS – STATE LAW (DURING COVID EMERGENCY)

- Some state requirements may have been waived
  - Ex: in-person visit requirement

MAJOR ISSUE #3: PRESCRIBING CS – STATE LAW (AFTER COVID EMERGENCY)

- States that waived certain prescribing requirements are putting those requirements back into effect
- Those requirements back into effect will need to be complied with
  - Regardless of whether federal waived requirements are back in effect

MAJOR ISSUE #3: PRESCRIBING CS – FEDERAL LAW ISSUE A = IN-PERSON VISIT REQUIREMENT (BEFORE COVID EMERGENCY)

- In-person visit prior to prescribing CS has been federal law since Ryan Haight Act (RHA) in 2008
  - Very few limited exceptions

FEDERAL LAW

- Controlled Substances Act (as amended by RHA)
  - "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 LAW

- Controlled Substances Act (as amended by RHA)
  - "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 LAW

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

FEDERAL LAW

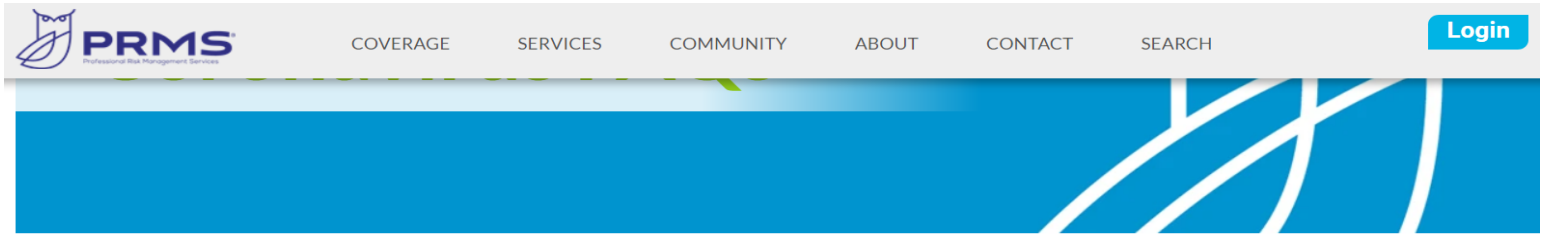
- Controlled Substances Act (as amended by the RHA)
    - 7 definitions of telemedicine / 7 exceptions to in-person visit
        1. Patient in facility with federal DEA registration – but need your own DEA registration in patient's state
        2. Patient in presence of a treater with DEA registration in patient's state – but need your own DEA registration in patient's state

FEDERAL LAW

- Controlled Substances Act (as amended by the RHA)
  - 7 definitions of telemedicine / 7 exceptions to in-person visit
    3. Indian Health Service
    4. Public health emergency
    5. Special registration from Attorney General
    6. Medical emergency
    7. Other circumstances, as deemed by Attorney General and Secretary

MAJOR ISSUE #3: PRESCRIBING CS – FEDERAL LAW ISSUE A = IN-PERSON VISIT REQUIREMENT (DURING COVID EMERGENCY)

- DEA waived in-person visit requirement for duration of federal COVID Public Health Emergency (PHE)
  - “Likely” to continue to be renewed throughout 2021
  - 60 days notice prior to expiration



UPDATED: September 1, 2021

NOTE: Please remember that we are all operating in uncharted territory and there are very few clear answers. If you are insured through PRMS, watch for more details about "Let's Talk" - a new resource providing more in-depth risk management thoughts on your many questions without answers.

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
- Seeing Patients in Your Office **(Added 8/30/21)**
- Five Things to Know About the Ryan Haight Act **(Added 7/28/21)**
- Preliminary Analysis Chart to determine if state licensure is relevant **(Added 1/14/21)**
- Preparing For What's Next - To Do List **(Updated 7/2/21)**
- State Guidelines For Re-Opening a Medical Office **(Updated 3/30/21)**
- Telepsychiatry and COVID-19: What We Do and Do Not Know On-Demand Tutorial
- Telepsychiatry Checklist **(Updated 8/30/21)**
- Telepsychiatry: Keeping Up With Your Regulators' Waivers **(Added 2/19/21)**

Online Courses

PRMS® clients can log into PRMS U to access a wide variety of CME and non-CME courses on many relevant topics.

ACCESS PRMS U

HIPAA HELP

Do You Know Enough About HIPAA?

To help you learn how HIPAA affects you and your practice, The Psychiatrists' Program offers a HIPAA Help checklist to make you more familiar with these regulations.

VIEW HIPAA HELP

http://www.prms.com/services/risk-management/coronavirus-faqs/

MAJOR ISSUE #3: PRESCRIBING CS – FEDERAL LAW ISSUE A = IN-PERSON VISIT REQUIREMENT (AFTER COVID EMERGENCY)

Donna's predictions:

- In-person visit requirement under RHA will almost certainly go back into effect
- Unknown when – if ever – DEA will do the telemedicine registration as ordered by Congress

MAJOR ISSUE #3: PRESCRIBING CS – FEDERAL LAW ISSUE B = DEA REGISTRATION IN PATIENT'S STATE (BEFORE COVID EMERGENCY)

- DEA required DEA registration in both prescriber's state and patient's state, if different
  - Since 2007
- Some physicians started to have applications denied if they didn't list a practice address the state

MAJOR ISSUE #3: PRESCRIBING CS – FEDERAL LAW ISSUE B = DEA REGISTRATION IN PATIENT'S STATE (DURING COVID EMERGENCY)

- Requirement is temporarily waived for duration of federal COVID PHE

MAJOR ISSUE #3: PRESCRIBING CS – FEDERAL LAW ISSUE B = DEA REGISTRATION IN PATIENT'S STATE (DURING COVID EMERGENCY)

Donna's predictions:

- DEA registration in patient's state will probably come back into effect
  - $
- Not sure how practice address issue will resolve
  - Uptake in DEA visits

Medical Provider Request and Consent for Continuity of Medication Management

MICA Student Health Services by Chase Brexton

Patient Name: _____ DOB: _____ Today's Date: _____

Dear Provider:

The staff at the **MICA Student Health Services** is pleased to assist your patient with medication management while attending school in Baltimore, Maryland. In order to provide safe and appropriate care, we request that you forward the last two office notes related to the medication(s) indicated below for our records. Please indicate on the form below the frequency of office visits to the MICA Student Health Services that you recommend, as well as any special instructions for medication monitoring (i.e – lab work, urine toxicology screening). We will require that the student return to your office at least annually for routine follow-up or at the interval agreed upon between you and the student. We defer all dose adjustments to you unless there is clear communication with our office regarding a change in the plan of care. Please do not hesitate to contact MICA Student Health Services so that we may best coordinate care for this student.
Thank you,

Simmone deBeaubien, RN, BSN
RN Clinic Manager, MICA Student Health Services

****

Medication #1 _____
Sig: _____:_____
Recommended frequency of office visits: _____
Special instructions: _____

Medication #2 _____
Sig: _____:_____
Recommended frequency of office visits: _____
Special instructions: _____

Provider Name (print) : _____ **Date:** _____

**** Provider Signature:** _____ **

Telephone number: _____ **Fax number:** _____

This consent will expire one year from the date of provider signature

Please fax the consent, the last two office notes, and a signed Release of Information for future communication to the MICA Student Health Services

(rev 5/2014)

St. John's College

Harrison Health Center Policy for ADHD Medication Management

The Health Center at St. John's College provides medication management for students who have been previously diagnosed with ADD/ADHD. Since ADD/ADHD is commonly treated with medications that are legally controlled substances, The Health Center has established policies that regulate the prescribing of medications for ADD/ADHD. The purpose of these policies is to ensure the safe and legal use of these prescriptions.

Below is a list of our policies:

- Students MUST provide appropriate documentation from their prescribing medical provider (see attached verification of ADD/ADHD form) before a prescription can be refilled at the Health Center. There are no exceptions.
- Students will not possess a controlled substance without a legitimate prescription. The student will not give or sell these medications to others. This is not only illegal but very dangerous.
- By law, controlled substance prescriptions must be written for no more than one month's supply.
- Prescriptions will not be renewed earlier than 25 days from the previous prescription date.
- Lost, stolen, or damaged prescriptions will not be replaced.
- Monthly visits are required for prescription refills. These visits will include blood pressure and weight checks.
- Since ADD/ADHD often requires more than medication management, students may be referred to other resources, such as counseling services, for optimum management.
- Students are required to have a follow up evaluation with their ADD/ADHD managing medical provider or psychiatrist at least every 6 months.
- Violation of the Student Health Center policies concerning controlled substances may result in termination of ADD/ADHD prescription refills at the Health Center.
- Students who have not been previously diagnosed with ADD/ADHD and desire an evaluation will be referred to counseling services for an initial evaluation. The student will then be provided a referral to a local psychiatrist for a complete evaluation.

“It’s a baby. Federal regulations prohibit our mentioning its race, age, or gender.”

MINOR ISSUE #1: HIPAA (BEFORE COVID EMERGENCY)

- Need to comply with HIPAA to ensure patient information is kept confidential and secure
  - Need business associate agreement from telemedicine platform vendor promising to protect patient information
  - State AG can enforce federal HIPAA regulations
- State law also requires patient information to be kept secure and confidential

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

MINOR ISSUE #1: HIPAA (DURING COVID EMERGENCY)

- OCR temporarily waived requirement to use HIPAA-compliant telemedicine platform during federal COVID PHE
  - Patients need care
- But…..risky for psychiatrists to use non-compliant platform

Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

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.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security and Breach Notification Rules (the HIPAA Rules).

During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.

OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.

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

Covered health care providers that seek additional privacy protections for telehealth while using video communication products should provide such services through technology vendors that are HIPAA compliant and will enter into HIPAA business associate agreements (BAAs) in connection with the provision of their video communication products. The list below includes some vendors that represent that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA BAA.

- Skype for Business / Microsoft Teams
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me
- Google G Suite Hangouts Meet
- Cisco Webex Meetings / Webex Teams
- Amazon Chime
- GoToMeeting
- Spruce Health Care Messenger

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

SUSTAINABILITY

Physician cybersecurity

PRINT PAGE

CONTENTS

Updated Aug. 31, 2021

Cybersecurity overview

Viruses, malware and hackers pose a threat to patients and physician practices. The AMA has curated resources and has tips for physicians and health care staff to protect patient health records and other data from cyberattacks.

MINOR ISSUE #1: HIPAA (AFTER COVID EMERGENCY)

Donna's predictions:

- OCR will go back to requiring HIPAA-compliant telemedicine platform
- More states may explicitly require HIPAA compliance

MINOR ISSUE #2: CONSENT (BEFORE COVID EMERGENCY)

- States infrequently addressed
- Consent to treatment modality of telemedicine
  - In addition to any necessary consent for treatment itself

MINOR ISSUE #2: CONSENT (DURING COVID EMERGENCY)

- More states are putting out telemedicine expectations
  - Consent to telemedicine is required / expected
- Samples exist online
  - Ex: search “MIT telehealth consent form”

MINOR ISSUE #2: CONSENT (AFTER COVID EMERGENCY)

Donna's predictions:

- No change – consent to use of telemedicine will continue to be required
- More states may explicitly require consent

MINOR ISSUE #3: DOCUMENTATION (BEFORE COVID EMERGENCY)

- Required to document visit
  - Same as if in-person

MINOR ISSUE #3: DOCUMENTATION (DURING COVID EMERGENCY)

- More states putting out telemedicine expectations / requirements
  - Including documentation

MINOR ISSUE #3: DOCUMENTATION (AFTER COVID EMERGENCY)

Donna's predictions:

- No change – documentation of visits, phone calls, etc. still required
- More states may explicitly require documentation

MINOR ISSUE #4: FOLLOW-UP/MONITORING (BEFORE COVID EMERGENCY)

- Rarely addressed by states
- Standard of care for telepsych is the same as for in-person
  - Track labs ordered
  - Take calls / questions between appointments
  - Etc.

MINOR ISSUE #4: FOLLOW-UP CARE/MONITORING (DURING COVID EMERGENCY)

- Some states have put out telemedicine expectations / requirements
  - Including the need to provide follow-up care of telemedicine patients

MINOR ISSUE #4: FOLLOW-UP CARE/MONITORING (AFTER COVID EMERGENCY)

Donna's prediction:

- More and more states will explicitly require follow-up and monitoring of telepsych patients

MINOR ISSUE #5: CONTINGENCY PLANNING (BEFORE COVID EMERGENCY)

- Telemedicine standards (such as ATA) required planning for clinical emergencies and technology failures
  - Get patient's actual location at start of each telepsych session, in case you need to send emergency services
  - Contingency plan for technology failure can be a telephone call
- Very few states required this

MINOR ISSUE #5: CONTINGENCY PLANNING (DURING COVID EMERGENCY)

- More states started to require contingency planning, especially planning for technology issues

MINOR ISSUE #5: CONTINGENCY PLANNING (AFTER COVID EMERGENCY)

Donna's prediction:

- More states will explicitly address