TELEPSYCHIATRY COMMITTEE

Telepsychiatry Practice: Legal and Regulatory Issues

Pamela Hoffman, MD, and the Telepsychiatry Committee

Technological advances over the past decade have converged with increasing mandates for universal mental health care coverage (Affordable Care Act, Public Law 111-148) to make telepsychiatry a viable option for children and adolescents (youth) who are not well served by traditional models of psychiatric care. Telepsychiatry generally refers to the use of interactive, real-time telehealth technologies to deliver care by a psychiatrist at one location to a patient at a distant location (Yellowlees, et al. 2010). Telepsychiatry has the potential to redistribute the child and adolescent psychiatry workforce, strengthen the skills of our primary care colleagues through collaboration in providing mental health care, and provide child and adolescent psychiatrists with options for their professional lifestyles. In response to the AACAP membership’s increasing interest in this evolving field, the Telepsychiatry Committee is presenting a series of articles on establishing and sustaining a telepsychiatry service. Best practices, standards (or definitions), and guidelines for in-person care apply to telepsychiatry, although additional regulations also apply (for an excellent review see: Kramer and Luxton 2013). These regulations pose a changing landscape at the federal and state levels that involve both delivery of care and reimbursement for services (Thomas and Capistrant 2015a; 2015b). In this first article, we present the key legal and regulatory foundations of a telepsychiatry practice.

- **Licensure Standards.** The 10th Amendment of the United States Constitution grants the individual states control over establishing and enforcing licensure requirements for health care professionals (Kramer and Luxton 2013). The potential of telepsychiatry to deliver care across boundaries has challenged the limits of the state-based licensure system and stimulated discussion of alternative approaches such as national licensure, specific telemedicine licensure, and reciprocity of licensure. However, movement on this issue is slow. While the Federation of State Medical Boards supports the creation of an “interstate compact” licensure system, the American Medical Association supports the existing state-based licensure system. Currently, most states require the provider (e.g., telepsychiatrist) to hold a specific state license corresponding to the physical location of the patient, as well as to the location of the provider. Of note, the site of practice is considered to be the location at which the patient is receiving care, not the location at which he/she resides. Some states allow reciprocity of license to neighboring, or “border,” states (www.license-portability.org). Psychiatrists should check with the requirements of the state medical boards where they plan to provide services.

- **Location standards.** Approved sites of telemedicine practice vary by state with respect to the physical location of both the patient and the provider. Generally approved sites include medical and mental health facilities. More variably approved are nursing homes, assisted living facilities, schools, other community sites, and home-based services. In addition to defining location, several states require a “presenter,” or “telepresenter,” to accompany the patient, while other states require that a health care professional be present on the premises, and other states make no specifications (Thomas and Capistrant 2015a).

- **Security and Privacy.** Ensuring compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is not achieved by following a simple checklist of technical requirements, such as ensuring HIPAA’s 128 bit encryption standard, but by following a process demonstrating due diligence to protect patient privacy and data. Potential telepsychiatrists should determine whether a technology vendor is compliant with HIPAA requirements and check relevant state privacy laws that may have more stringent privacy and security requirements.

The American Telemedicine Association has highlighted the importance of obtaining informed consent with patients in real-time (Yellowlees et al. 2010). Some recommended elements for consent include: confidentiality and limits to confidentiality when using electronic communications; emergency plan; documentation and storage of information; potential for technical failure and procedures for coordination of care with other professionals; protocol for contact between sessions; and conditions under which services are terminated and a referral for face-to-face care made (Kramer and Luxton 2013). Laws regarding age of consent vary from state to state.

- **Pharmacotherapy.** Medications that are not regulated by the Drug Enforcement Administration (DEA) can be prescribed consistent with methods used in traditional practice. Scheduled medications have additional regulations. Providers should be aware of the Ryan Haight Online Pharmacy Consumer Protection Act (Public Law No. 110-425, H.R. 6353 2008) that regulates Internet prescribing and the Drug Enforcement Administration Final Rule that implements this statute and defines telemedicine (Department of Justice...
2009). These regulations have been open to some interpretation, such as defining the patient-provider relationship and the requirement for the presence of another licensed provider at the patient’s site. This legislation notes that the temporary definition of telemedicine would be applied “until the earlier of two dates: (i) three months after the date on which regulations are promulgated to carry out 21 U.S.C. 831(h) [relating to the issuance of a special registration to practice telemedicine] or (ii) January 15, 2010” (Department of Justice 2009). Further action from the DEA is anticipated in 2016. Providers should review the DEA policy, as well as medical practice laws within their own state and at the patient’s location, given its clear relevance to the use of stimulant medication in child and adolescent psychiatry.

**Emergency Care.** Local civil commitment laws and duty to warn/protect requirements vary by jurisdiction. Providers should abide by state regulations at both the patient and provider sites. Similarly, requirements for mandated reporting of child endangerment to Child and Protective Services vary by state. Providers should be informed of the local requirements, procedures, and phone numbers for mandated reporting at the patient site. Emergency procedures should be established prior to initiating services and discussed with the site and patient at the initial encounter or as part of informed consent (Shore et al. 2007). The role of the parent in emergency service planning must consider age of consent. Providers should identify procedures and staff at the patient site to involve in crisis situations.

**Liability Issues.** As telepsychiatry is an evolving field, malpractice insurance carriers may cover such services, but not explicitly state such in a policy. Potential telepsychiatry providers should examine their policies and discuss coverage with their carrier, including whether such coverage includes patients physically located out of state.

**References**


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See the following links for helpful information:

- American Telemedicine Association: www.americantelemed.org
- Center for Connected Health Policy: http://cchpca.org
- Center for Telehealth and e-Health Law: http://ctel.org/
- Telehealth Resource Centers: www.telehealthresourcecenter.org
- Centers for Medicare and Medicaid Services: www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html
- Patient-Protection and Affordable Care Act: http://www.hhs.gov/healthcare/about-the-law/read-the-law/index.html