Chapter 13
Implications of Legal and Regulatory Issues in Telebehavioral Health

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Introduction

Starting a telebehavioral health program from scratch seems like a daunting task, and many organizations try to pave the way themselves. The telebehavioral and telemedicine communities have many resources and many programs are willing to share their experiences and lessons learned. Looking online for nationally recognized telebehavioral health programs provides many opportunities to network with other organizations. Many professional associations including the American Psychiatric Association, the American Psychological Association, the American Social Work Association, and the American Telemedicine Association act as resources as well and have many online tools available. Focusing on the specific responsibilities of the clinician to the patient, the organization to the patient, and the clinician and organization's responsibility for legal, ethical, and moral practices are key to a successful program.

This chapter: (1) highlights some of the common legal and regulatory, privacy, and security issues for healthcare; (2) discusses how those govern use of telebehavioral health; and (3) provides guidance on navigating the issues for providers and health systems.

Case Study: Starting a Telebehavioral Health Program – The Provider's Perspective

A small psychiatry practice has decided to use Telebehavioral health. At present, the group practice is an in-person practice located along the border of three states. Patients are seen from all three states. The providers in the practice are enrolled in all three states' Medicaid programs, as well as the majority of health plans as an

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in-network provider. The group practice has two psychiatrists, three certified psychiatric nurse practitioners (CPNPs), and intake and medication management registered nurses. The group also includes four licensed clinical psychologists providing therapy and two licensed clinical social workers providing supportive services. The group wants to start using telebehavioral health for medication management, therapy, and supportive services. The group is unsure where to start and contacts a local telehealth resource to begin to learn about telemental health.

At the end of each section of this chapter, an update to the case study will be found.

Analysis/Take Home

1. Legal and regulatory issues are an important part of planning and implementing a telebehavioral health program. Taking advantage of lessons-learned, templates, and other experts that are available to assist in the planning process helps a mental health provider or other organizations considering telebehavioral health to be in compliance with the legal and regulatory environment.
2. Licensure requirements for practice across state lines are not only about the process of licensure. How that licensure is obtained is only one factor. Additional factors involved include determining the scope of practice, supervision requirements for advanced level practitioners, collaborative practice agreements, patient compensation funds, and malpractice insurance. These components need to be considered and thought through as components of a multistate licensing strategy.
3. Policies and procedures play a key role in helping a mental health provider move through the steps of setting up a telebehavioral health program. These same policies and procedures are also a written validation of how a mental health provider approaches, trains for, monitors, and meets compliance regulations for audits, certifications, and quality reviews from internal processes and external agencies.

Scope of Practice

Scope of practice is defined or described as the services that a qualified health professional is deemed competent to perform and permitted to undertake in keeping with the terms of their professional license (American Nurses Association [ANA], 2021). The scope of practice is typically under the purview and jurisdiction of state law and state licensing boards. Scope of practice may vary from state to state. These requirements for scope of practice are often based on the education and training of certain health care professionals and the qualification that those health care professionals need to attain to accept full and unrestricted licensure to practice the health profession (American Medical Association [AMA], 2021). In using telebehavioral health, clinicians, whether physicians, licensed clinical psychologists (LCP), licensed clinical social workers (LCSW), or other licensed mental health professionals, must practice within their professional scope of practice, the same as in-person care. For instance, an LCSW cannot diagnose a patient, only a physician can

diagnose. An LCP cannot prescribe medication. Certain mental health professionals can order testing, others cannot. The same standards for scope of practice set for in-person care apply to all situations of virtual or remote-based care (telebehavioral health). Mental health professionals, who practice outside of the scope of their license when seeing patients via telebehavioral health, run the risk of sanctioning by the individual's state licensing board and permanent loss of license.

Many a times the scope of practice relates back to the definition of such practice, such as the definition of the "practice of medicine." The definition of specific practice will include the need for supervision or the degree of independence in which the professional may practice, prescriptive authority, the ability to independently interpret diagnostic testing (radiograph interpretation), and the need to have a collaborative practice agreement in place (Rivera et al., 2014. Health professionals who are practicing via telemedicine or telebehavioral health must be aware of all of these requirements that fall under scope of practice and adhere to those requirements as in-person care. Some of these requirements are discussed further in this chapter.

Questions about scope of practice can be directed to the individual health professional's corporate compliance or legal office or can be directed to the individual's professional association advocacy or legal teams. Individuals can also contact state licensing boards for clarification of scope of practice when using telebehavioral health, although many times, these discussions lead to more confusion. In some situations, the scope of practice may be more limited due to telemedicine laws in individual states or by individual licensing boards.

In working through scope of practice issues before a health professional begins to use telebehavioral health as a tool for access, specific questions should be answered. Questions to be answered include:

1. How is the scope of practice defined?
2. Who regulates the scope of practice?
3. When does the scope of practice change if at all?
4. Who is responsible for adherence to the scope of practice:
5. Does the scope of practice change when telebehavioral health is used?
6. Are there special conditions under the Pharmacy Act in the state?
7. Are there any other state-specific scope of practice laws for telehealth or telebehavioral health?

Using these questions as a guide will allow the health professional to identify any scope of practice issues and adapt the practice to operate within the scope of practice in addition to updating policies and procedures to reflect the scope of practice guidelines.

Case Study Implications As the psychiatry practice begins to move forward with telebehavioral health, the group considers three levels of practitioners – those that are independent (MDs and in some states CPNPs), those that have collaborative practice or supervision requirements (CPNPs, LCPs, LCSWs), and registered nursing requirements for scope of practice. Each state was reviewed for collaborative practice requirements and supervision requirements and those specific requirements

were put into a table format. The number of charts reviewed and the length of review time are examples of the types of supervision requirements that need to be documented for each state.

Ethical Practice

The use of telehealth does not remove any existing responsibilities in delivering services, including adherence to the Code of Ethics, Scope of Practice, state and federal laws, and professional association documents on professional practice, and the quality of services must be consistent with the quality of services delivered in person. When considering ethical practice issues, the health professional again must adhere to all ethical codes of conduct similar to in-person care when delivering services via telebehavioral health. For physicians, the practice of medicine is "inherently a moral activity founded in a covenant of trust between patient and physician" (Pellegrino, 2002). This type of trust and moral responsibility can and is generalized to all health professionals and upholds the belief that patients and their delegates should and need to be able to trust that the clinicians will put the patient and family needs first and foremost (AMA, 2012). Patients and families must be able to trust that health professionals will provide competent care, enough information for patients to make educated decisions, take steps to protect the patient's privacy, and will ensure continuity of care (AMA, 2017).

These same standards of ethical practice apply to telebehavioral health and other forms of remote-based care. Health professionals have an ethical duty to the patient in the forms of trust, privacy, competency, and continuity, the same as in-person care. Unethical behaviors, attitudes, or beliefs by health professionals are equally egregious via telebehavioral health as these behaviors are in person, and are subject to the same penalties, restriction or loss of license, and prison terms as the penalties for in-person care.

Unethical practices in telebehavioral health may include such behaviors as neglecting to meet with clients during the set times, changing information in a contract or client's file to make a mental health agency or professional look professional, neglecting to respond to crisis calls or visits, having dual relationships with clients, extending care for the purposes of revenue generation, retaining or using the services of an incompetent health professional, changing a diagnosis, fabricating documentation, having clients engaged in personal work for the health professional, and stalking behaviors (Anchored Child and Family Counseling, 2021).

Any questions regarding the ethical practice of telemedicine should be answered again, by the individual's corporate compliance or legal office, the health professions association, or at minimum, a review of current literature for position statements, advisory opinions, or other consensus documents on what constitutes and what is outside of the ethical practice when telebehavioral health is used.

An example of a comprehensive scope of practice, professionalism, and ethical conduct comes from the American Medical Association, which says:

> "Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physicians' fundamental ethical responsibilities do not change, the continuum of possible patient–physician interactions in telehealth/telemedicine gives rise to differing levels of accountability for physicians.
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> All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate.
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> Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles.
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> Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:
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> (a) Inform users about the limitations of the relationship and services provided.
> (b) Advise site users about how to arrange for needed care when follow-up care is indicated.
> (c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.
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> Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:
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> (a) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.
> (b) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patient's site conduct the exam or obtaining vital information through remote technologies.
> (c) Be prudent in carrying out a diagnostic evaluation or prescribing medication by:
> (d) Establishing the patient's identity
> (e) Confirming that telehealth/telemedicine services are appropriate for that patient's individual situation and medical needs
> (f) Evaluating the indication, appropriateness, and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction
> (g) Documenting the clinical evaluation and prescription. When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and

surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.

As in any patient–physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients' preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient's primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient. Collectively, through their professional organizations and health care institutions, physicians should:

(a) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.
(b) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.
(c) Routinely monitor the telehealth/telemedicine landscape to:

1. Identify and address adverse consequences as technologies and activities evolve
2. Identify and encourage dissemination of both positive and negative outcomes (AMA, 2021).

Case Study Implications The human factors of communicating online, especially when asynchronous tools are used such as email or chat, promote a sense of risk at times that people take who would otherwise not act in specific ways if physical distance were not a factor. As the world has seen the rise of social media bullying, and other inappropriate behaviors due to the anonymity of the internet, or for other reasons, it is vitally important that medical and behavioral health specialists pay strict attention to the ethical practice of their profession. The behavioral health group in the case study decided to have a subcommittee of one of each of the mental health disciplines to research, study, and write a policy regarding ethical behavior when telebehavioral health is used. In reality, the use of telebehavioral health does not change the ethical responsibilities of the clinician to the patient, thus, organizational policies and procedures must identify the differences in communicating via interactive video or asynchronous methods and put in place a policy that includes audit practices, patient complaint reporting, requirements for training for providers, and an outline of disciplinary actions that could be taken against a provider who engages in unethical practices via telebehavioral health. The responsibility chain for complaints, investigation, and decision-making, and the authority to do so, was also spelled out in the mental health group's policies. These policies also served as a benchmark for quality reporting, for state and federal audits, and for certifying bodies such as the Joint Commission and other state or federal agencies (i.e., CMS).

Supervision

Supervision requirements for mid-level practitioners do not change when the service is delivered via telebehavioral health. Health professionals either in a supervisory position or those that require supervision must be aware of the professional association and governing body requirements for supervision of students and practitioners, and if and when, those requirements change from state to state.

The requirements for supervision must also be understood which are dependent on definition. For instance, supervision requirements for residents according to the Accreditation Council for Graduate Medical Education (ACGME) defines supervision of residents in the following manner:

> VI.D.3 a) Direct Supervision – the supervising physician is physically present with the resident and patient.
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> VI.D.3.b) Indirect Supervision:
>
> VI.D.3.b).(1) With direct supervision immediately available – The supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision.
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> VI.D.3.b).(2) With direct supervision available – The supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities and is available to provide Direct Supervision. Common Program Requirements 15
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> VI.D.3.c) Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered (Accreditation Council for Graduate Medical Education [ACGME], 2021).

An example of how these supervision requirements are interpreted is as follows from ACGME's guidance:

> Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care (ACGME, 2011).

Each health profession will have similar regulatory requirements for supervision as well as the individual's state licensing boards. Imperative to the health professional is the need to investigate supervision requirements, especially when telebehavioral practice is across state lines. An example of an interesting supervision requirement is found in the following example.

In a Midwest health care organization, a nutrition professional who was also a registered diabetes educator, worked in a pediatric oncology practice. The pediatric oncologist supervised the nutritionist's practice, which required direct supervision (physically present in the same location) whether the patient was seen in person or via telemedicine. The pediatric oncologist went on outreach once a week to a clinic 150 miles away and once the practice started using telemedicine, wanted the nutritionist, who did not go on outreach, to see the patients via telemedicine. The pediatric oncologist and the patient were physically present in the same location. The nutritionist was in another location. Due to the supervision requirements, even though the patient and the supervising clinician were in the same location, the supervised health professional (nutritionist) was not in the same location as the supervising clinician. This scenario, thus, did not meet the requirements for supervision and the nutritionist could not use telemedicine to see the patient. Although the scenario seems counterintuitive in that the supervisor and the patient were in the

same location, and supervision requirements are intended to protect the patient, the spatial relationship between the nutrition professional and the supervising clinician did not meet the regulatory requirements for supervision.

Important supervision questions to ask include, what is the definition of supervision that is required? Does the use of telebehavioral health change that definition or requirements for immediate availability, physical distance/presence, or timeliness? If the basic requirement of supervision cannot be met when telebehavioral health is used, then the health professional is in violation of practice acts and supervision requirements.

Case Study Implications In the mental health workgroup for telebehavioral health, supervision requirements were identified for advanced practice providers in three states. These requirements were identified during the research on scope of practice noted above and were confirmed by the medical staff services office (one person) of the practice. LCPs had supervision requirements in a few states and could practice independently in other states. LCSWs had supervision requirements in all states. A chart was developed that included each state and the supervision requirements for all advanced level practitioners. For those states that also required licensure, a licensure column was added to the chart. A policy on supervision was then written to reflect the current supervision requirements for each state and outlined what was needed to meet the requirements. The supervision program already in place at the mental health group was then updated to reflect the requirements for telebehavioral health practice. The procedure outlined the frequency and number of chart reviews, observations, and other requirements for supervision for each professional discipline. The policy was scheduled to be updated each year (instead of every 3 years) or more often if regulatory requirements changed. The medical staff services person was charged with an audit of all states in which the advanced-level practitioners saw patients via telebehavioral health on a quarterly basis and to update policies as needed.

Documentation

Documentation in the medical or mental health record is an important part of delivering comprehensive and coordinated care. In its simplest form, the reason documentation is important is that it provides all the information about a specific individual patient that the health care team may need to make appropriate and accurate assessments and decisions about that patient and is essential to meeting standard of care. Adverse patient outcomes such as medication and procedural errors that can result in death or comorbid conditions can result from poor or incomplete documentation. Ethical behaviors for all health professions include the requirement to provide adequate documentation in the patient's record to assure that standards of care are met and that patient safety and confidentiality are preserved (Kanaan, 2017).

The basic principle of documentation for telebehavioral health visits is to document the same as though the health professional had seen the patient in person. If the telebehavioral professional has a hybrid practice with in-person patients and telebehavioral health patients, and uses a common electronic health record for both, then the same documentation templates or tools should be used for both encounters, with a notation in the documentation for the remote patient that the patient was seen via telemedicine. If the health professional uses two different tools, one for in-person care and one for telebehavioral health patients, the same requirements for documentation exist in both scenarios. All elements of the psychiatric exam and assessment must be documented as done, unable to complete, or incomplete, with the appropriate notes as to findings or why each component was not accomplished. Although SOAP notes are a common documentation strategy in many telehealth platforms, these types of short notes may not be appropriate for many mental health professional encounters via telebehavioral health.

Documentation serves two other important functions – risk management and coding and billing. In health care the old saying is "If it isn't documented, it wasn't done!" Documentation must support the necessary level of billing that reflects the care delivered. If the care delivered rises to a Level III 99211 office visit, then the documentation must support the complexity of care delivered that is billed under this CPT code.

In the event of a patient complaint or an adverse event, Risk Management will look to the documentation in their investigation to determine what happened to the patient and the situation that transpired. Incomplete or skimpy documentation is not helpful when Risk Management is trying to mitigate damage or liability or to support a patient complaint. It is imperative therefore, that the mental health professional document complete and accurate notes in compliance with scope of practice, ethical, risk management, and coding and billing practices, as well as for continuity of care, when telebehavioral health is used.

Case Study Implications The mental health provider group understood from the literature and working with other telemental health groups that documentation for telebehavioral health visits must be the same as in-person care. In addition, the documentation and visit must be able to be identified as a result of a virtual type of visit. The mental health group established a different appointment type for a telebehavioral visit in their existing electronic health record and also required providers to name the document "TH" and check a box that the visit was done via telebehavioral health. That checkbox then created a link to the document, which showed in the patient's record as the telebehavioral health visit. When audits occurred, certification reviews or other performance management processes were held, distinguishing between an in-person visit and a telebehavioral visit becomes automated through database queries of the chart.

Billing and Coding

Similar to documentation, billing and coding practices should be the same as in-person care with a few caveats. Again, if the care is not documented, the coding and level of billing cannot be up-charged, even though it is well known that the health professional does uphold the standard of care. Coding can only rise to the level of documentation and health professionals do not want to leave money on the table due to lack of documentation. Coders rely only on documentation in the medical record to support the level of billing charges sent to the billing system and on to payers. Payers may audit charges and ask for supporting documentation. If the supporting documentation is incomplete or not sufficient to support the level of charges, then payment will either be reduced or denied. Coders should also not down-charge a visit simply because the visit is done by telebehavioral health. At one organization in the southern part of the United States, a coder down-charged all of the charges placed by the clinician for telemedicine visits as she thought the visits were done by telephone. Education of coders and the billing staff is imperative to retain the level of revenue associated with in-person care.

Billing for services delivered via telebehavioral health requires a matrix approach and automated billing editing processes to ensure that the right codes, modifiers, and place of service are used for billing purposes. The professional services department of any organization using telemedicine must be familiar with Medicare, Medicaid, private payer, accountable care, and other regulatory payment models for services delivered via telemedicine or telehealth. The actual requirements for billing government and private payers are extensive and would require their own separate chapter. However, for the purposes of this discussion, the following approach can be used by a health professional's billing service or department to approach and accurately submit claims for services delivered via telebehavioral health (Antoniotti, 2005). Each payer source has a different algorithm for determining payment and are *mutually exclusive!* One payer algorithm cannot be applied to another payer source for determination of payment. Remember also, that during times of national disasters or public health emergencies, that restrictions for payment for services delivered via telehealth, telemedicine, or telebehavioral health for originating sites, eligible practitioners, approved services, etc., may be waived under emergency orders. Daily checks for eligibility for payment should be done in cases of public emergencies (Fig. 13.1).

The process for determining eligibility for Medicaid is somewhat different than Medicare, which is more of a linear algorithm. Medicaid agencies are all different and at liberty to set their own policies for payment for services delivered via Telehealth. The health professional's billing company or department must ask a series of questions and then determine if there are any conditions of payment not met that would preclude the submission of a claim and payment for services. Questions to be answered are included in Fig. 13.2 (Antoniotti, 2005). If all the requirements are met, then the claim should be submitted to Medicaid. If any of the requirements are not met, do not bill Medicaid.

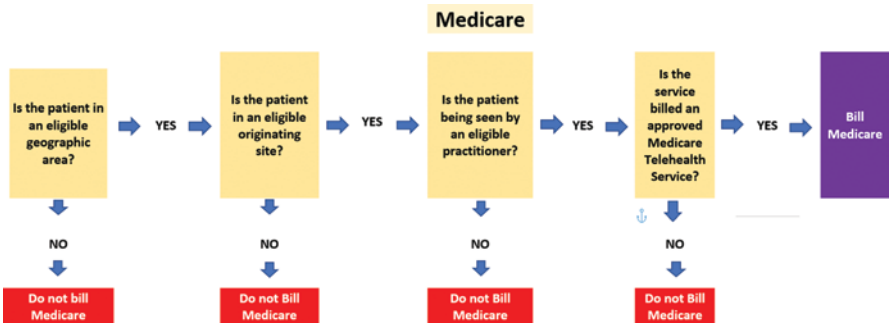

Fig. 13.1 Medicare payment algorithm

Private payers each will have their own policies for reimbursement and payment for telebehavioral health and often have more robust payment models for mental health services via telemedicine. As one of the original telemedicine services in the United States, telepsychiatry has been used since 1974, with the earliest program being in Nebraska and funded by the National Institute of Mental Health, Washington, D.C. Many Medicaid programs started payment strategies around telepsychiatry in the early 1990s.

In addition to these algorithms for payment eligibility, claims are also subject to an appropriate place of service (POS) and telemedicine modifiers. Medicare does not require a modifier except for telestroke but does require a place of service POS 02 Telehealth. Medicaid agencies typically require the modifiers of GT for telemedicine and a place of service reflecting the actual location of the patient. Some Medicaid agencies have adopted the 02 Telehealth POS. Private payers all use 95 Telemedicine as the modifier and the POS of 02 Telehealth.

Health care providers' billing systems should be set to edit any telebehavioral health encounters to apply logic to identify the type of visit (use a telehealth appointment type), then identify the payer source (Medicare, Medicaid, private payer), then change the POS and modifier based on the payer source requirements, and then submit the claim. Many organizations flag telehealth encounters or visits for a manual review to ensure that the right modifier and POS is on the claim to avoid denials. A good billing system, however, will be able to automate this review and apply the necessary logic to have the electronic claim corrected before being submitted to the payer.

Case Study Implications The mental health provider uses an outside vendor for coding, billing, and submitting claims. The mental health provider met with the vendor to discuss the need to create a process for claims management that identifies the payer source (government, state, private, self) and attached the correct place of service (02) and the correct modifier (GT, 95, none) for the appropriate and specific health plan. The vendor already had in place the necessary workflow to ensure that government payers were not billed when not appropriate and that the correct place of service and modifiers were selected for individual health plans. The mental health

Fig. 13.2 Questions for medicaid payment eligibility

provider requested a monthly report to review all telebehavioral health visits to ensure compliance. The report included the MRN, date of service, provider, patient name and demographics, CPT or HCPCs codes billed with descriptions, the amount billed, the amount paid, discounted, patient-pay, or bad debt noted by column.

Licensure

For the purposes of remote based care, virtual care, telemedicine, or telebehavioral health, the assumption about interstate licensing is that the health professional needs to be licensed in the state in which the patient resides or is located at the time of care. There are several ways to obtain such licensing depending on the health professional and the state in which licensure is sought. Some health professions, such as genetic counselors, are licensed in some states and not in other states. Mental health therapists are called different names in different states and have different licensure requirements with subsequently different scope of practices. For instance, a master's prepared social worker may be called a Licensed Social Worker (LSW), a Licensed Clinical Social Worker (LCSW), a Mental Health Professional (MHP), etc., depending on the state. It is incumbent upon the health professional who practices across state lines to know the licensure requirements for each state of telepractice, the licensing board rules (for in-person visit, prescribing, supervision, requirements for annual CME or CEUs), the corporate practice of medicine, and any exceptions, expedited licensing, telemedicine licenses, or waivers that may be in place in order to practice via telemedicine across state lines.

The use of interstate licensure compacts has come into favor in the last decade with the Interstate Medical Licensure Compact from the Federation of State Medical Boards being the most successful example of licensure compacts. Physicians who are licensed in a member state of the compact have portability of their home state license to other compact member states. With an application to the Interstate Medical Licensure Compact Commission (ILMCC), a physician is accepted by the ILMCC and then can add states for additional fees. Many other health professions have interstate licensure compacts including Registered Nurses (NLC), Physical Therapy (FSBPT), Emergency Medical Services Personnel (EMS Compact), Psychologists (PSYPACT), Occupational Therapists (AOTA), and others.

Health professionals who are not licensed in a state in which they practice remotely are subject to penalties and criminal action associated with practicing without a license in that state. Health professionals should work with their Medical Staff Services or Legal Services departments to research requirements for licensing in the state in which the patient resides at the time of the visit in order to avoid any licensure sanctions.

Case Study Implications The mental health provider group took an inventory of all licensed providers including in which state that provider was licensed. In a four state market, not all states had a licensed provider status for the mental health

provider. The group decided to have one MD and two NPs licensed in each state. The physicians were licensed through the Interstate Medical Licensure Compact Commission and each nurse practitioner has to be individually licensed in all the states including meeting the requirements for collaborative practice.

Other Legal and Regulatory Issues

Health professionals using telemedicine and telebehavioral health should also be aware of the legal and regulatory issues associated with areas of legal practice that might arise depending on the level of practitioner, prescribing authority, and insurance, among others. A few of these areas are described below.

1. *DEA and Controlled Substances* – for prescribers who also hold DEA licenses with controlled substances prescribing authority, state and federal laws may restrict the ability to prescribe controlled substances via telebehavioral health. It is imperative that controlled substance prescribers are aware of state and federal regulations that govern prescribing Schedule II drugs. Many states require an in-person visit before being able to prescribe controlled substances via telebehavioral health; others do not permit prescribing at all. The Ryan Haight Act and the DEA govern legislated and regulatory requirements for prescribing controlled substances via telemedicine and should be thoroughly understood before prescribing controlled substances during or after a telemedicine or telebehavioral visit (US Dept. of Justice, Drug Enforcement Agency [DEA], 2021a, 2021b). A unique set of regulatory requirements also govern and exempt providers who are trained in Medication Assisted Therapy to treat opioid abuse and other controlled substance addictions (DEA, 2021a, 2021b).
2. *Malpractice Insurance* – Most current day malpractice carriers cover a health professional when that professional uses telemedicine or telebehavioral health. Some carriers require an additional no-cost rider or charge additional fees for coverage for telebehavioral health. Health professionals should always check with their malpractice carrier to determine if (1) the carrier covers the practice when using telemedicine or telebehavioral health; (2) in what states is the carrier licensed to offer coverage; and (3) are there any additional coverage requirements from the carrier that are needed before starting a telebehavioral component to the practice?
3. *Federal* versus *State Requirements* – Often confusing to health professionals first starting out in telepractice is the conflict that at times appears between the regulatory requirements for state and federal telemedicine or telebehavioral practice. In general, state law always supersedes federal law when the state law is more restrictive or allows for more rights to the consumer, such as a minor's right to seek certain health care services including mental health care. In other situations, federal law will supersede state law, especially in the areas of Medicare reimbursement. Health professionals who sense or discover a discrepancy between

state and federal law are prudent to retain legal counsel or use the corporate compliance or legal offices to provide an opinion on the discrepancy and recommendations on how to proceed.

4. *Corporate Practice of Medicine* – the corporate practice of medicine should always be considered when crossing state lines to practice via telebehavioral health. Currently, half of the states continue to restrict the "corporate practice of medicine" (either by statute or based on common law as interpreted in court decisions). Telehealth programs may invoke state corporate practice of medicine restrictions if services are provided by anyone other than the individual licensed professional's corporate organization that they own and control. The challenge for multistate or national programs is to work within the requirements of the corporate practice of medicine doctrine. Being able to do so requires that the health professional team and the corporate legal team work together to address issues surrounding the corporate practice of medicine and address any issues during the planning stage. Also remember that corporate practice of medicine restrictions may apply to professions other than physicians (e.g., Illinois corporate practice of social work) (Mazur, 2017).

Organizational Approach to Legal and Regulatory Issues

Each health care organization embarking upon a telemedicine or telebehavioral practice must ask a series of questions to determine and discover any legal or regulatory issues that need to be investigated and questions answered. For instance, an example of the planning questionnaire for a new program might be (Table 13.1) (Antoniotti, 2005):

Following this list of questions will generate additional questions and the need to seek additional information. A good telebehavioral health program assessment and implementation plan should always generate more questions that definitely should be answered and documented, then analyzed for a go–no go decision making process. The implementation team must include representatives from clinical practice, administration, legal, compliance, medical records, billing and coding, risk management, and optimally, patients and families (consumers). A well-represented implementation team will discover and solve any legal or regulatory issues that present during the planning phase of a telebehavioral health program.

Policies and Procedures for a Telebehavioral Health Program

Policies and procedures for telebehavioral health practice and programs follow, for the most part, in-person care with a few additions. The type of policies and procedures needed also depend on the model of care delivery – is the program a direct-to-consumer cash service? Is the program a direct-to-patient for established patients

Table 13.1 Telebehavioral health program planning questions

1. What service is being provided?
2. Who is providing the service?
3. To whom is the service being provided?
4. Where is the location of the patient?
5. What hours of service are intended?
6. What is the business model to be used?
7. What is the financial model to be used?
8. What is the relational model to be used?
9. How are referrals obtained and executed?
10. What are the payment requirements and payer mix?
11. What are the rules around payment?
12. What are the licensure requirements if interstate practice is anticipated?
13. Are there supervision and/or collaborative practice agreements required?
14. Does the current malpractice carrier cover telemedicine?
15. Is consent required for telemedicine?
16. Is informed consent required for telemedicine?
17. Is an in-person exam required before the patient can be seen via telemedicine?
18. Does the service/state/payer require an established patient–provider relationship?
19. Will a physical exam be conducted?
20. What are the prescribing requirements?
21. What are the credentialing requirements?
22. What is the technology to be used?
23. Other questions?

using insurance? Is the practice a hybrid of in-person office visits and telebehavioral health visits? Is the practice seeing patients unknown to the provider? Is the practice doing initial assessments, on-going therapy only, prescribing, or all of the above?

In addition, the location of the patient also drives specific needs for policies and procedures. If patients are seen in their own homes versus being in an outpatient clinic with a telepresenter or other health care professionals nearby, or in an inpatient unit, the need for and type of policies and procedures vary.

Basic policies and procedures include those policies and procedures that already exist in the organization for areas such as human resources (hiring, disciplinary, firing, licensure, credentialing, etc.), HIPAA and Privacy, annual training requirements, vacation/sick/PTO, diversity and inclusion, and patient rights and responsibilities. These basic policies typically do not need to be re-created for the telebehavioral practice when that practice is a part of an existing organization with in-person care. However, if the telebehavioral practice is a new practice and new corporate entity, then these basic policies and procedures governing the everyday operation of an organization with employees or subcontractors, need to be written and in compliance with local, state, and federal laws.

Advanced procedures include procedures that address the actual virtual or remote practice of telebehavioral health and identify those components of a remote practice

that differ or present unusual scenarios or predicaments not necessarily covered in the basic policies and procedures. Examples include how to respond to a patient in crisis when the patient is at home, consent and withdrawal of consent at a distance, authentication of the patient and provider, how to maintain privacy and confidentiality, and emergency and escalation procedures. Providers need to be aware of how to address patient needs at a distance (not standard of care which is a part of clinical practice, but those unusual components of practicing when the patient is not in the same room), the differences in interview and exam techniques, how to get help for the patient in crisis, and how to get advanced level of professional assistance when the provider is out of their expertise in dealing with a patient real time, for example.

The organization should also use software and hardware to access telemedicine platforms that comply with HITECH requirements (Health and Human Services [HHS], 2021). An example of such a policy is found at the end of the chapter. This example shows categories and thought processes associated with each of the categories in HIPAA and HITECH that apply to telebehavioral health encounters and the technology used to accomplish these encounters. These security policies should also include sections on how providers will be authenticated to use the systems and how patients are authenticated to download apps, use urls to access platforms, and also login procedures and how to authenticate users who need to reset passwords or forgot usernames. When proxies are used for patients (minors, incapacitated adults, ward of the courts, other), the same procedures must be in place and documented for linking the legal consenter as a proxy to the patient including written procedures that outline which documents are required to support and substantiate the legal relationship of the proxy to the patient as consenter.

Specific Policies and Procedures

Specific policies and procedures for telebehavioral health service providers include the following:

1. Clinical Practice
2. Consent and Withdrawing Consent
3. Using APPs
4. Documentation Requirements
5. Patient Safety
6. Problem Patient
7. Emergency Treatment
8. Ethics Violation
9. Training, Guidance, Management, Auditing

Several examples of such policies are noted below. When writing policies and procedures, a standard format should be used that includes the policy statement, applicability, the procedure body, definitions, other references or policies/procedures associated with the policy and procedure, and revision history. The policy owner should be clearly identified. For organizations that are Joint Commission accredited or have other certifications from agencies or groups, attention should be paid to the

required list of policies and procedures that are needed to attain such designations or certifications.

Example 1. Problem Patient Policy and Procedure

Policy/Procedure	Problem Patient	**Document Number**
Document Author		**Last Updated Date**
Policy/Procedure Owner		**Revision Number**

Purpose

The purpose of this policy is to outline the approach and procedures for handling problem patients or family/caregivers including escalation of such events to the appropriate level for determination and intervention.

Scope

The scope of this policy applies to all employees including nonclinicians and nonlicensed employees working at or a subcontractor to [organization name].

Policy Definitions

A problem patient is defined as a "difficult" patient who may be profoundly annoying, poorly compliant, belligerent, antagonistic, etc., and interrupts the patient–provider relationship to such a degree that the patient's progress is inhibited or halted completely.

Policy

Problem Patients.

Patients can be problematic for all staff and be physically and mentally intimidating to staff. Dealing with problem patients requires enhanced communication skills, intuition, quick thinking, and empathy. Not all problem patient situations can be resolved. The following policy applies to problem patients at [organization name].

1. All patients regardless of their interaction with staff shall be treated with dignity and respect.
2. Patient and staff safety are the highest priority in problem patient situations.
3. All staff shall be trained in dealing with difficult patients and the responsibilities to act and report when a problematic situation arises with a patient.
4. Staff must understand that anger is a manifestation of other patient concerns and it is important to diffuse the situation or end the behavior of the patient as soon as possible.
5. Problem patients at [organization name] include:

   (a) Patients who consistently do not follow the treatment plan;
   (b) Patients who misuse the [organization name] app;
   (c) Patients who exhibit inappropriate behavior or responses towards coaching or clinical staff;
   (d) Patients who repeatedly miss scheduled appointments;
   (e) Patients who misrepresent their identity;
   (f) Patients who exhibit drug seeking behavior;

(g) Patients who are angry and unable to control their anger and participate in treatment;
(h) Patients who threaten [organization name] staff;
(i) Other safety concerns for [organization name] staff;
(j) Patients who exhibit other repeated behaviors that are nonclinical but still a concern to staff.

6. Staff who encounter problem patients shall complete the problem patient form online and submit the form to the Patient Advocate who will investigate the situation.
7. The Patient Advocate will refer the problem patient situation to the [name of] Committee when the results of the investigation indicate a need to contact the patient regarding the behavior, request that the patient cease the behavior, or if there is a need to change providers or terminate the patient from the [organization name] service.
8. The [name of] Committee retains the ultimate right to terminate patients from the [organization name] service.
9. If a patient is terminated from the [organization name] service, the patient will receive a registered letter to the address on record and receive the same notification through the [organization name] app.
10. One week post date of the mailing of the registered letter to the patient and the notification through the app of patient termination, the patient's [organization name] app account will be turned off.
11. Patients who are terminated from the practice will not be allowed to sign up for [organization name] services for 12 months.

Related Policies, Procedures, and Other Materials

Revision History		
Revision Number	**Revision Date**	**Revision History**

Example 2. Ethics Violations Policy and Procedure

Policy	Ethics Violations	**Document Number**
Document Author		**Last Updated Date**
Process Owner		**Revision Number**

Purpose

The purpose of this policy is to outline the procedures for reporting ethics violations including patient complaints, escalation of patient needs, reporting of concerning practices, and all other suspected violations of ethical practice.

Scope

The scope of this policy applies to all employees including nonclinicians and nonlicensed employees working at or a subcontractor to [organization name].

Policy Definitions

None

Policy Provisions

Ethics Violations

1. Providers and employees must be aware of the top ethical concerns that might present in a mental and behavioral health practice including:

   (a) Client's rights and informed consent
   (b) Ethical issues with multicultural counseling
   (c) Confidentiality
   (d) Competence
   (e) Working with multiple clients (couples and groups)
   (f) Counseling minors
   (g) Dual relationships
   (h) Working with suicidal clients
   (i) Counselor Training and supervision
   (j) Law & ethics

2. Ethical violations at [organization name] include but are not limited to the following:

   (a) Practicing without a license
   (b) Intimating, developing, or having a sexual relationship with a client including minors
   (c) "Other" – poor standard of care, violation of ethics code, inadequate supervision
   (d) Inappropriate insurance or fee assessment
   (e) Failure to properly conduct child custody evaluations
   (f) Failure to inform clients of the goals, techniques, rules, and limitations of counseling
   (g) Breach of confidentiality
   (h) Failure to report abuse
   (i) Failure to report clear and imminent danger
   (j) Failure to properly form and facilitate groups
   (k) Sexual misconduct w/ minors
   (l) Nonsexual dual relationships
   (m) Practicing outside of competency
   (n) Inappropriate follow-up/termination

3. All employees at [organization name] shall complete Ethics training and be aware of and know how to access the Patient Complaint form, the Ethics Violation reporting system, and the [organization name] Patient Advocate and Legal Services.
4. All employees at [organization name] are responsible for reporting Ethics violations or suspected violations immediately and are held responsible for patient safety concerns if the employee person delays reporting in any way.
5. Employee shall follow the process for Ethics violation reporting by:

(a) Contacting the Corporate Compliance Officer or designee and providing all information including the reporting employee's name and contact information. The Corporate Compliance Officer or designee will complete the reporting form and start an investigation.
(b) Talk with the employee member's supervisor who will document the incident and take the matter to the [organization name] Corporate Compliance officer to complete the report.

6. Employee members who report ethics violations are not entitled to the outcomes of the investigation but will be notified that the investigation was concluded.
7. Employee members who are investigated for ethics violations will be subject to the following actions:

(a) The investigation is complete and there are no findings. The report will stay in the employee member's file for 1 year; or
(b) The investigation is complete and there are minimal findings that indicate clinical practice could have been different or behavior could have been more professional but no patient harm or ethical violations occurred. The employee member will be counseled and the investigation report and report of the counseling session and recommended changes will stay in the employee's file for 1 year; or
(c) The investigation is complete and there are moderate findings that indicate clinical practice should have been different or behavior should have been more professional and patient harm could have occurred but did not. The employee will receive a verbal warning to improve behavior and/or practice with expected outcomes and the verbal warning will remain in the employee's file for 2 years; or
(d) The investigation is complete and there are significant findings that indicate evidence-based practice was not followed or behavior violated the patient–provider relationship and patient harm could have occurred but did not. The employee will receive a written warning to improve behavior and/or practice with expected outcomes and the verbal warning will remain in the employee's file for 2 years; or
(e) The investigation is complete and there are severe findings that indicate clinical practice did not follow evidence-based practice and/or professional behavior professional and patient harm has occurred. The employee will receive disciplinary action including a 3 days suspension up to termination of employment. The findings will remain in the employee's file for 5 years. Employees who are terminated as a result of ethics violations are not subject to rehire.
(f) Significant or severe findings are reported to the appropriate licensure board and government agency if required by the Corporate Compliance Officer.
(g) The employee may appeal a minimal, moderate, or significant finding, through the Corporate Compliance Officer Appeals process. A severe finding may not be appealed and the findings stand.

Related Policies, Procedures, and Other Materials

Revision History		
Revision Number	**Revision Date**	**Revision History**

Case Study Conclusions As one can see throughout this chapter, the mental health group embarking on a plan to implement telebehavioral health uses valuable resources to educate itself, identify key legal and regulatory issues, create policies and operational procedures to meet all the legal and regulatory requirements, and put in place a quality performance program that monitors compliance. The mental health group used online resources for policies and procedures and made adjustments to those templates to make policies that reflected the practice model and philosophies of the group practice. In this way, the mental health provider group was able to launch a successful telemental health program that was compliant, successful, and generated a high level of patient and provider satisfaction.

Conclusion

Starting from scratch in writing policies and procedures seems like a daunting task and many organizations try to pave the way themselves. The telebehavioral and telemedicine communities have many resources and many programs are willing to share policies and procedures. Simply looking online for university-based programs or other nationally recognized telebehavioral health programs will provide many opportunities to network with other organizations. Many professional associations including the American Psychiatric Association, the American Psychological Association, the American Social Work Association, the American Telemedicine Association, and others concerned with public policy and clinical guidelines for the use of remote-based care in the behavioral health sciences. Remember always that the use of policies and procedures outline the specific responsibilities of the clinician to the patient, the organization to the patient, and the clinician and organization's responsibility for legal, ethical, and moral practice. In addition, policies and procedures assist organizations and clinicians in supporting the best in evidenced-based, patient-centric care that promotes organizational clinical quality.

CE/CME Questions

1. Providers must be aware of the licensure requirements when conducting telebehavioral health visits?

   (a) No license is required if telebehavioral health is provided in rural areas
   (b) Licensure is up to each state's practice board requirements

(c) Licensing for telebehavioral health is available through some professional licensure compacts
(d) Providers need a special telehealth license to practice virtually
(e) Physicians cannot be licensed in multiple states for telemedicine practice

2. What key legal and regulatory issue should providers be aware of when considering a Telebehavioral health program?

(a) Licensure, malpractice insurance, location of patient, revenue
(b) Malpractice insurance, revenue streams, patient satisfaction, compliance
(c) Licensure and compliance
(d) Compliance, malpractice insurance, location of the patient
(e) Licensure, compliance, location of the patient

3. Scope of practice issues include:

(a) Prescribing authority
(b) Supervision needs
(c) Evidence-based practice
(d) Licensure requirements
(e) Insurance requirements

4. Policies and procedures are an important part of conducting a telebehavioral health program :

(a) Policies and procedures govern what the patient does
(b) Policies and procedures govern what the provider does
(c) Policies and procedures help attorneys know what to do
(d) Policies and procedures govern the relationship between the provider, the patient, and the health care organization
(e) To allow attorneys to create a case against a patient

5. What is the reason that an organization must have a policy on Ethical Behavior in telebehavioral health care?

(a) To protect the provider
(b) To protect the organization
(c) To protect the patient
(d) To help win a malpractice case
(e) To reduce malpractice insurance costs

Answers

1. (b)
2. (e)
3. (b)
4. (d)
5. (c)

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