What Happens when the Public Health Emergency Ends?

Telepsychiatry & Hybrid Practice Post-PHE

AMERICAN PSYCHIATRIC ASSOCIATION

Telepsychiatry Policy Frequently Asked Questions (FAQs)

This FAQ covers discussion items from the American Psychiatric Association's webinar, ***What Happens when the Public Health Emergency Ends? Telepsychiatry and Hybrid Practice Post-PHE****, that took place on January 11, 2023 and related questions that have come to APA via the Practice Management Helpline.*

Background

The COVID-19 public health emergency (PHE), which began in January of 2020, kicked off a cascade of policy and regulatory flexibilities that have changed the role of technology in mental health care. With the PHE ending on May 11, 2023, we collected the most common questions that APA members have asked about telepsychiatry and hybrid care.

Telepractice

What telehealth requirements that were waived under the PHE will go back into place when the PHE ends?

The primary telehealth flexibilities extended beyond the end of the PHE involve Medicare coverage. Flexibilities that were not extended include telehealth exams for prescription of controlled substances, DEA registration in one state allowing prescription of controlled substances in any state, use of non-HIPAA-compliant messaging software, and the ability for licensed clinicians to bill Medicare for services in states in which they are not licensed. On May 12, 2023, the day after the PHE ends, clinicians will be required to have had an in-person visit with a patient in order to prescribe controlled substances, will be required to have a DEA license in any state in which they are prescribing controlled substances, and will be required to use HIPAA-compliant messaging software (software that has a BAA) for telehealth. Since all state-level PHEs have ended, licensure flexibilities have already ended in most instances. ***Take a look at this resource*** from APA for an overview of telehealth policies during and after the PHE.

What changes did the Consolidated Appropriations Act, 2023 (CAA 2023) make to telepsychiatry policy?

Policy changes in the federal year-end spending bill – CAA 2023 – included some important victories for the practice of psychiatry. Notably, the act delayed the implementation of Medicare's in-person requirements through at least the end of 2024. As of now, some in-person requirements for Medicare mental health services will go back into effect in 2025 but stay tuned for updates. Please note that this flexibility only applies to billing Medicare for services delivered to Medicare members, not to other regulations that govern the delivery of care.

Can I maintain my practice completely virtually? How about if I'm prescribing controlled substances?

While in-person requirements for billing Medicare have been delayed through the end of 2024, other payers, including Medicaid and commercial payers, as well as your state legislature or state medical board, may be re-instituting in-person requirements to deliver care in your state. Further, if you are prescribing controlled substances, the waiver of the Ryan Haight Act's requirement to see patients in person expires the day the PHE ends. Therefore, while it is theoretically possible to maintain an all-virtual practice for the time being, it is advisable to ensure that you or another psychiatrist have the ability to see patients in-person, either for clinical or regulatory reasons.

Is there one set of rules or regulations I can follow to understand what services I can deliver via telehealth?

Unfortunately, no. There are difering federal, state, and facility regulations governing licensure, reimbursement, and prescriptive authority.

Controlled Substances

Has the DEA issued the Ryan Haight special registration for telemedicine? If not, what are my options?

No, the DEA has not yet issued the telemedicine special registration that may enable some clinicians to prescribe controlled substances without an in-person exam. We hope to see this rule soon. We recommend that you start preparing now to maintain continuity of care for your patients when in-person exam requirements return by securing office space where you can see patients in person, establishing plans to refer patients to a clinician that can conduct the required in-person exam, or not taking new patients that require controlled substances prescriptions.

What requirements for remote prescribing of controlled substances go back into place when the PHE ends?

Per the DEA's current interpretation of the Ryan Haight Act, you can continue to prescribe controlled substances to a patient that you have seen in person, at least once, even pre-pandemic, within your clinical judgment. The Ryan Haight Act does not set an "expiration date" or frequency requirements associated with prescribing controlled substances. Any patient you have not seen in person, including those you established via telehealth during the pandemic, will need to be seen in person before you can issue any new prescriptions for controlled substances. As a reminder, state or facility rules or clinical considerations can impose frequency requirements or best practices (e.g., that you have to see patients in person annually).

Wait, so I am not required to conduct an in-person exam for controlled substances on a regular schedule? One exam counts for compliance with the Ryan Haight Act?

Correct. Once an in-person exam has occurred, the Ryan Haight Act does not mandate frequency or recurrence. Decision-making about appropriate timeframes for in-person care is the responsibility of the prescribing clinician. Take a look at **APA's Ryan Haight Act overview** for additional information.

Are there any exceptions to the Ryan Haight Act's requirement to see a patient in person before prescribing controlled substances?

There are extremely limited "practice of medicine" exceptions that do not apply to the vast majority of clinical situations (e.g., don't apply when the patient is at home, don't apply to the general population, or don't apply outside of emergency settings). These exceptions are: the patient being treated in-person in a DEA-registered hospital or clinic, the patient being treated via telemedicine by a DEA-registered practitioner for the Indian Health Service, the patient being treated via telemedicine by a Veterans Health Administration (VHA) practitioner during a medical emergency recognized by the VHA, or the telemedicine service taking place during a federal public health emergency (like the one we're in now!). There is an additional circumstance written into the Ryan Haight Act: that the practitioner has obtained a "DEA special registration for telemedicine." Please note that this is the special registration mentioned above, which does not exist yet, so this option is not available for use by clinicians.

Can prescribers apply for exceptions to the in-person requirement to prescribe controlled substances based on hardship or clinical decision-making?

No. Once the PHE ends, there are no exceptions to requirements for an in-person visit prior to the prescription of controlled substances based on patient or clinician hardship or clinical decision-making. The only exceptions are the "practice of medicine" exceptions listed above.

Can another clinician prescribe controlled substances for my patient? What if I've never seen the patient in person?

The Ryan Haight Act describes the special circumstance of a "covering practitioner" - "a practitioner who conducts a medical evaluation [by telemedicine] at the request of a practitioner who … has conducted at least 1 in-person medical evaluation of the patient or an evaluation of the patient through the practice of telemedicine within the previous 24 months; and is temporarily unavailable." The "covering practitioner" allowance in the Ryan Haight Act does not replace the requirement that the prescribing clinician has conducted an in-person exam. It does allow for a colleague who has never seen the patient in person themselves to prescribe on your behalf through a telehealth exam on a short-term basis, as clinically appropriate and within the law.

I've been prescribing controlled substances to a patient that moved to another state. Can I keep doing so?

Only if you obtain a DEA registration in that state, which requires a physical location in that state. During the PHE, a clinician with a DEA registration in any state can prescribe controlled substances to a patient in any state via telehealth if the prescription is issued for a legitimate medical purpose, the clinician is acting in the usual course of professional practice, and the consult is conducted via live, synchronous video (with audio) interaction. This geographic flexibility expires the day the PHE ends.

During the PHE, can I prescribe controlled substances using audio-only telehealth modalities?

No. A video visit is required in order to prescribe controlled substances via telehealth. Per DEA PHE rules, "DEA-registered practitioners … may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided … The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system."

Can patients refill prescriptions after the PHE ends? Do in-person requirements only apply to new prescriptions?

Short answer – we don't know. While you can be sure that new prescriptions will require a history of an in-person visit, interpretation and enforcement around refills may vary. We will track this and share any updates.

Licensure

Can I continue to see patients in other states?

With the end of most state public health emergencies, all states currently require that you are licensed or registered in the state in which you are treating the patient (meaning the state where the patient is physically located when they receive care from you). As we mentioned earlier, some states, like Florida, have mechanisms to register for a telemedicine license in the state, which is different from a license to have a physical practice in the state. You can look at your specific state's policies in this **Telemedicine Policies by State resource** from the Federation of State Medical Boards, but assume that you will need to be licensed where your patients are. This could mean that your patients travel into a nearby state where you are licensed, or that you help them find a psychiatrist that is licensed in their state.

Can I provide telehealth services to a patient that is out of the country? Can I provide telehealth services while I am out of the country?

Providing telehealth services to a patient that is located in a country in which you don't have a medical license would be practicing without a license. Instead, we recommend that you work with the patient to provide continuity of care while transitioning the patient to a local clinician. If the patient is in the US and you are not (but are licensed in the US), your ability to provide care may vary based on the patient's insurance policies – so find out how they are planning to pay and investigate accordingly. It's advisable to check with your malpractice carrier before delivering care across national borders. Providing care in a country that you aren't in may also make it more difficult for you to provide necessary emergency services or referrals.

Coverage & Billing

What will Medicare cover?

While there was a limited in-person visit requirement for Medicare mental health services in the Centers for Medicare and Medicaid Services (CMS) 2023 Physician Fee Schedule, CAA 2023 removed in-person requirements to bill Medicare through the end of 2024. There are no in-person requirements in Medicare until at least 2025. Audio-only is a permanently allowable telehealth modality in Medicare, including after the PHE flexibilities end.

How will commercial and Medicaid payers be covering telehealth in 2023?

Commercial and Medicaid payers will vary widely in their coverage policies. While most states have some state laws governing private payer telehealth reimbursement policies, and all states reimburse for live video telehealth in fee-for-service, there are wide variations in modalities, services, and providers covered. You can connect with your APA District Branch, state medical board, and other trusted resources to assess coverage for your patients in your state.

What rules apply to me if I don't take insurance at all?

State and federal laws governing licensure, prescriptive authority, and other requirements like patient data management (e.g., HIPAA, 42 CFR Part 2) likely still apply to you even if you're not billing insurance. Rules in the CMS Physician Fee Schedule don't apply to you if you're not taking Medicare or when you are providing care to non-Medicare patients. However, a good rule of thumb is to use CMS rules as a baseline for your practice to help you stay in compliance across settings and patient populations.

What is the difference between modifiers 95, 93, and FQ in Medicare?

Modifier 95 in Medicare denotes live video telehealth. 93 and FQ both denote audio-only telehealth services. FQ is Medicare's existing modifier, and 93 is what many commercial payers have been using, so Medicare is allowing providers to bill either 93 or FQ or both for audio-only services. RHCs, FQHCs, and OTPs have to bill modifier 93 and may also bill FQ. We recommend that you bill both as it is allowable and covers your bases. You can start billing these modifiers starting after the 151-day PHE flexibilities end – so on the 152nd day after the PHE ends. We have confirmed with CMS that this is the case even given Medicare flexibilities in the CAA 2023.

Selected Resources

- **APA's Telepsychiatry Toolkit** and **Telepsychiatry Blog**
- APA Practice Management Helpline: practicemanagement@psych.org
- **APA's Comparison of Telehealth Provisions During & After the Public Health Emergency**
- APA's **Ryan Haight Act overview**
- **SMI Adviser:** Receive guidance on person-centered treatment of serious mental illness from expert colleagues
- Federation of State Medical Boards' **Telemedicine Policies by State**
- Center for Connected Health Policy's **Telehealth Policy Finder**
- **Ryan Haight Act**
- **DEA's COVID-19 Telemedicine Policy**

Have any questions you didn't see addressed in here? Need additional support? Email aworthen@psych.org with questions or comments.

Sign up for updates to our **Telepsychiatry Toolkit** and **sign up** to receive **advocacy updates** and alerts.