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Preparing for the Telehealth World: Navigating Legal, Regulatory, Reimbursement, and Ethical Issues in an Electronic Age

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As technology advances, psychologists increasingly have the opportunity to engage with patients or other users of psychological services via less traditional methods. However, little guidance exists to prepare psychologists to navigate the legal, regulatory, reimbursement, and ethical issues that can arise when providing psychological services via technology. A review of relevant state and federal laws reveals inconsistencies even in the terminology used to describe provision of services via technology with some referring to "telehealth," others to "telemedicine," and others using additional terms. The following overview of laws, regulations, and existing guidelines in the area of telehealth and telemental health provides some preliminary guidance for psychologists as they attempt to meet the needs of their patients using available and emerging technologies. Specific issues addressed include the applicability of the HIPAA Privacy and Security Rules, informed consent and reimbursement by third party payers.

Keywords: telehealth, telemental health, privacy, security, reimbursement, technology

With the proliferation of wireless devices such as smart phones and PDAs, and the availability of Internet-based videoconferencing and social networking, health care providers are able to connect easily and virtually with patients without requiring face-to-face encounters. Whether the communications are limited to scheduling appointments or involve providing psychological interventions remotely, using this technology for delivery of health care services has raised unique issues relating to how these services are coordinated and delivered virtually. While using technology to provide virtual services can enhance and increase access to care, such as for rural populations or linguistic minorities, the technology itself creates new challenges and potential risks that psychologists need to carefully consider. Not only are psychologists ethically obligated to attain and maintain competency in specific practice areas and/or in working with specific populations, psychologists who use telehealth technology must also be competent in using the technology. Psychologists, like other health care providers, confront a lack of uniformity and clear guidance on legal, regulatory, and ethical requirements regarding reimbursement policies, privacy and security issues, and even best practices for using this technology to provide psychological services.

This lack of uniformity begins with the threshold issue of what we should call this particular area of practice. Various terms such as "telehealth," "telemedicine," "e-health," and even "m-health" are used by the provider community, legislators, policymakers, and payers. Telehealth is often used as the broader term to describe electronic information and telecommunications technology used to support and improve clinical health services, health administration, patient information, public health, and professional education and supervision. Telemedicine is often used to refer to the narrower category of delivery and support of clinical services. However, the terms are frequently used interchangeably as there is yet no universal definition or term used by legislators, policymakers, government agencies, and payers. Within the realm of behavioral health, terms such as "telemental health," "e-mental health," "telepsychology," or "telepsychiatry" are often used. Telepsychology is further complicated in that this term is sometimes used to describe all psychological services, including those outside of health care, that are delivered via technology. For purposes of this article, telehealth is used to define the delivery of clinical health care services via technology. Telemental health is used when specifically referring to behavioral health care services delivered through technology.

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Regardless of which term is used, it is important to take note as to how the term is defined in specific contexts. For example, some payers may define telehealth services narrowly, limiting reimbursement only to services provided using interactive audio-video conferencing. Some telehealth laws may only recognize certain provider types, such as physicians only or medical providers including only physicians, nurses, and physician assistants.

As part of a 50-state review examining state laws, regulations, and psychology board policies and an informal phone survey of nearly all licensing boards around the country, the American Psychological Association (APA) Practice Directorate reviewed those state telehealth provisions, licensure/interjurisdictional practice issues, and any enforcement activity by licensing boards against psychologists using telehealth technology (American Psychological Association Practice Organization [APAPO], 2010). A few states have enacted telehealth or telemedicine laws applicable to psychologists. However, most states do not have specific telehealth provisions directly applicable to psychologists defining how they may use telehealth. A number of organizations have, however, written guidelines to provide information for individuals desiring to provide telehealth services, and psychologists may find these useful sources of information.[1]

Although the use of telehealth has not yet been widely adopted by legislators, policymakers, providers, or payers throughout the United States, psychologists interested in telehealth who live in jurisdictions lacking telehealth laws may not be automatically precluded from using telehealth so long as they carefully consider the relevant issues that impact telehealth practice and determine whether telehealth is appropriate for use in their practice. Issues specific to telehealth provision of psychological services across state lines require a separate review of laws related to interjurisdictional licensure and the possibility of unauthorized practice that will not be addressed in this article (APAPO, 2010). Instead, the focus of this article is on various legal and regulatory issues involving informed consent, patient confidentiality and security, and reimbursement. Although much provider to provider consultation is provided via technology and supervision of services certainly could be provided in this fashion, few laws or regulations specifically address these areas. Interestingly, few laws and regulations cover the provision of services via telephone either, although this is probably the technology most frequently used by psychologists in the delivery of care. Given the absence of legal and regulatory guidance, these areas are excluded from the focus of this article. It is incumbent upon the psychologist to become educated on any and all relevant laws that may impact the delivery of telehealth services, including state laws governing scope of practice issues. Both the APA and the Association of State and Provincial Psychology Boards (ASPPB) Model Acts for Licensure of Psychologists note that psychology may be practiced via electronic or telephonic needs but provide no further guidance. Lastly, psychologists should also consult with their malpractice insurance carrier for guidance as to whether telehealth services are covered.

Informed Consent

To date, a few states have enacted laws regulating how licensed psychologists may use telehealth in providing services to state residents (APAPO, 2010). In those states, telehealth is specifically defined in either statute or regulation, often spelling out what kinds of technology or communication are regulated. Furthermore, those state laws outline what information ought to be disclosed by the psychologist to the patient before providing services using telehealth communications. Although state requirements may vary, the underlying purpose for disclosure is intended to protect the client from risks inherent in furnishing services via telehealth.

Additionally, a number of state psychology licensing boards have issued an opinion or policy statement on the use of electronic communications or technology in providing psychological services. While these policies may not have the same weight as state statutes or regulations, they do provide some guidance for psychologists regarding appropriate practices as well as how boards might respond to complaints received involving a psychologist providing telehealth or telepsychological services. Similarly, those state board opinions have emphasized that psychologists must give careful consideration to the potential risks unique to telehealth as compared with face-to-face encounters.

For example, in Massachusetts, North Carolina, and Texas, the psychology licensing boards advise that psychologists must carefully consider issues such as informed consent, patient confidentiality, competency, and security before using telepsychology. Also, those board statements strongly encourage psychologists to advise patients about the possibility of technology failure and discuss methods of alternative communication in the event of technology failure; explain the procedure for contacting the psychologist when off-line; inform patients about using encryption methods to ensure secure communications, the potential risks to confidentiality when using unsecured communications, and whether and how electronic information produced during the telehealth encounters are stored and accessed. Those board statements also recognize the challenges of verifying client identity and determining whether the client is a minor, dealing with potential misunderstandings when visual cues are missed or unseen, and identifying a local mental health professional for crisis intervention or assistance.[2]

While most states have not enacted telehealth laws specific to psychologists or issued psychology board opinions on providing psychological services through electronic means, there are other relevant laws that psychologists ought to consider before engaging in telehealth services. For example, several states have enacted specific informed consent requirements for telehealth services—in addition to existing informed consent requirements—even in the absence of any state telehealth laws. As of spring 2011, the following states require health care providers including psycholo-

[1] For example, Ohio Psychological Association: Telepsychology Guidelines; Canadian Psychological Association: Ethical Guidelines for Psychologists Providing Psychological Services via Electronic Media; American Telemedicine Association: Evidence-Based Practice for Telemental Health, Practice Guidelines for Videoconferencing-Based Telemental Health; American Psychiatric Association: Telepsychiatry Via Videoconferencing Resource Document; American Counseling Association: Code of Ethics; American Mental Health Counselors Association: Code of Ethics; and National Association of Social Workers: Standards for Technology and Social Work Practice.

[2] Those states where the psychology licensing board has issued an opinion or statement about the issue of telepractice or provision of services using electronic means include Florida, Massachusetts, New York, North Carolina, Texas, and Wisconsin.

gists to obtain informed consent for telehealth services, including telepsychology services: Arizona, California, Kentucky, Oklahoma, Texas, Vermont, and Wisconsin. At a minimum, these states require psychologists to meet the same legal and ethical standards applicable to psychological services provided in-person. It is important to note that most of these states define telehealth as strictly limited to real-time audio-video conferencing.

Some of the above-mentioned states have broader requirements for what constitutes a valid telehealth informed consent. Those states specify that the informed consent must be provided verbally and in writing to the patient. The informed consent for telehealth must include notice of the patient's right to withhold or withdraw consent at any time without affecting the patient's right to future care, treatment, or program benefit; description of the potential risks and consequences of using telehealth; applicability of existing patient confidentiality and patient access protections; and assurances that patient-identifiable images or information from the telehealth encounter would not be disseminated to researchers or others without patient consent. In addition, providers must include the signed consent in the patient's record (Arizona's Telemedicine Statute, 2004; Telemedicine Development Act of 1996, Oklahoma Telemedicine Act, 1997). However, informed consent for telehealth is not required for telehealth consultations where the patient is not directly involved (e.g., consultation between providers) or in emergency situations when patient consent cannot be obtained easily or in a timely manner.

Other informed consent requirements may include notification to the patient about how electronic patient communications are stored, description of who may access those communications, discussion of when the psychologist would respond to routine electronic messages and under what circumstances the psychologist would use alternative (nonelectronic) communications for emergency purposes, and a description outlining the psychologist's reporting requirements mandated by state law (e.g., reports of possible patient self-harm or harm to others, or suspected cases or abuse) (Kentucky's Telehealth and Telepsychology Regulation, 2011). For example, Vermont specifies that psychologists must provide certain information, such as the psychologist's location, licensure, and training and where and how to make a complaint, if necessary, to patients in advance of providing services via the Internet or other electronic means (Vermont's Telepractice Regulation, 1999).

There is a great deal of consistency among the various state laws and board policies regarding mandatory or recommended disclosures that psychologists provide to patients before conducting telemental health services. Many of these informed consent requirements are mentioned in guidelines developed by other professional organizations that have examined the use of technology in providing health care services. Informed consent is especially important when providing telemental health services as there is a greater risk for miscommunications or misunderstandings that may be experienced negatively by the patient and potentially construed as abandonment or negligence. For psychologists who practice in jurisdictions that do not have any telehealth state laws or psychology board opinions, the above-described requirements provide a good deal of guidance as to what basic information, at minimum, ought to be disclosed to the patient and included as part of a valid informed consent for telemental health services.

Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, sets the federal privacy and security standards that will apply to most psychologists providing telemental health services. (There may also be state privacy and security laws that apply.) Typically, HIPAA applies when providers, including psychologists, electronically transmit patients' health information in relation to a claim for insurance or other third party reimbursement (APAPO, 2010).

The two relevant rules under HIPAA are the Privacy Rule and the Security Rule. The predominant focus of the Privacy Rule is on the rules governing intentional disclosures of protected health information (PHI). The rule, however, also requires covered health providers including psychologists to use reasonable safeguards to protect patients' PHI from unauthorized and unintended disclosures or uses (HIPAA Administrative Simplification Rules, 2003). But the Privacy Rule does not mandate specific actions or practices that must be taken to comply with the reasonable safeguards requirement. The Privacy Rule applies to PHI in all forms: electronic, paper, and verbal.

Protecting against unintended and/or malicious disclosure, alteration, or loss of electronic PHI is the primary focus of the Security Rule. This rule is narrower than the Privacy Rule in that it only applies to electronic PHI. Accordingly, the Security Rule applies primarily to practitioners who store or transmit electronic PHI. As discussed below, the Security Rule does not apply to communication with patients by videoconference, fax, or telephone.

As with the safeguards requirement under the Privacy Rule, the Security Rule does not mandate specific security measures or technology, such as encryption or password protection. Like the Privacy Rule, the Security Rule acknowledges the need for a flexible approach in establishing and implementing physical and technical safeguards. The Security Rule is "technology neutral" and does not require use of any specific technologies. In part, this reflects a recognition that technology and its attendant security risks and fixes change rapidly. A number of common security mechanisms include passwords, digital signatures, firewalls, data encryption, encryption over public networks, backup systems, and disaster recovery plans (Kumekawa, 2001).

E-mail and Videoconferencing

According to the Health and Human Services (HHS) Office for Civil Rights, the division charged with enforcing HIPAA, covered entities may communicate with patients electronically so long as reasonable safeguards are used when doing so. Examples of safeguards may include securing locations and equipment and implementing technical solutions to mitigate risks and workforce training. Practitioners communicating by email will also need to be fully compliant with the Security Rule (U.S. Department of HHS & The Office of the National Coordinator, 2008). Because the Privacy Rule's safeguards standard and the general approach of the Security Rule are flexible, providers are not required to comply with specific proscriptions for handling protected health information. Rather, providers and other covered entities can implement policies and practices most appropriate to the size, function, and needs of the individual provider or organization. The focus is on reasonableness.

Neither the Privacy Rule nor the Security Rule prohibits the use of email in communicating with patients nor necessarily requires encryption be used. That does not obviate the provider's duty to use other reasonable safeguards to protect privacy, such as checking email addresses for accuracy or limiting the amount or kinds of information contained in unencrypted communications.

In most cases, telemental health services rely on live audio-videoconferencing, not store-and-forward technology (asynchronous communications such as email or text messages which do not necessarily have real-time responses). While many university hospital organizations and other large health care delivery systems have private secure networks to receive, store, and transmit patient data, psychologists working in solo or small practices must use commercially available technology and applications (Milby, 2010). Videoconferencing is not considered the transmission of electronic PHI and therefore, the Security Rule is not applicable but the Privacy rule is (U.S. Department of HHS & The Office for Civil Rights, 2010). It is often unclear whether the commercially available software, web-based applications, or devices comply with HIPAA and other privacy laws.[3]

Overall, the basic Privacy Rule considerations for web-based videoconferencing for telemental health care are *what* potential risks to confidential patient information might using telehealth technology pose and *how* those risks can be appropriately minimized. Potential risks might include difficulty in verifying a patient's identity (this might be less of an issue when using telehealth with a longstanding patient and/or using videoconferencing); ensuring privacy at both the provider's location and the patient's location (unless expressly waived by the patient); potential disruptions in technology (e.g., Internet service); storing and maintaining information that is created or collected during the telehealth encounter (e.g., is the encounter being recorded?); assessing the potential for unauthorized access to such information if stored and maintained separately from other protected information; as well as potential risks for unintended or unauthorized disclosure if using unsecured communications when discussing or transmitting protected health information (Johnson & Bendixen, 2005).

Regardless of the specific technologies that covered providers might use in providing telehealth, the primary focus is ensuring against unauthorized or unintended disclosures of confidential patient information with particular attention paid to those risks unique to telehealth. How that is done and what kind of technology to use should be part of the risk assessment and management process, which may require consulting with IT professionals.

Telehealth Reimbursement

Despite the promise of harnessing telehealth technology to promote more efficient health care delivery and to improve access to health care services, the growth of telehealth programs has not been as robust as anticipated for the past couple of decades. One often cited reason for the underutilization of telehealth services is the absence of consistent, comprehensive reimbursement policies. This lack of an overall telemedicine reimbursement policy stems from "the multiplicity of payment sources and policies within the current United States health care system" where the vast majority of health care costs are paid by private insurers, Medicare, and Medicaid (Office for the Advancement of Telehealth, 2003, p. 2). While there is a lack of universal reimbursement for telehealth services, there has been some progress, albeit piecemeal, among public and private payers (Eder-Van Hook, Burgiss, & Waters, 2006).

However, a significant challenge in evaluating reimbursement policies is that many providers do not bill telehealth services differently than face-to-face services unless specifically required to do so, such as under Medicare. Without special modifiers or special CPT codes to track telehealth utilization, it is difficult to calculate accurately the volume of telehealth reimbursement (Brown, 2006).

Medicare

The Balanced Budget Act of 1997 (BBA) was the first federal law mandating Medicare reimbursement for certain telemedicine services. It is important to note that Medicare uses the term "telemedicine" rather than "telehealth." In 2000, Congress sought to address some of the limitations on Medicare reimbursement for telemedicine services in the Benefits Improvement and Protection Act of 2000 (BIPA), which was incorporated into the 2001 Consolidated Appropriations Act (Pub. L. No. 106–554). BIPA effected several changes to telemedicine reimbursement but still continues to limit coverage to only patients living in certain regions of the United States and receiving services at approved sites via live audio-video communications (Fleischer & Dechene, 2010; Whitten & Buis, 2007).

According to Section 15516 of the Medicare Carriers Manual, psychologists are included in the list of qualifying practitioners who may bill Medicare for telemedicine services. Section 15516 also provides that Medicare reimbursement for telemedicine services would be on par with reimbursement for the same service provided in-person (Center for Medicare and Medicaid Services [CMS], 2003). The conditions for coverage mandate using interactive audio-video telecommunications to permit real-time communications between the provider and Medicare beneficiary. While psychologists are eligible to provide covered telehealth services under Medicare and receive reimbursement, only services provided in rural health professional shortage areas (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA) are eligible. If the patient is not a beneficiary located in a non-MSA or rural HPSA, the psychologist cannot bill Medicare for telehealth services. The kinds of settings where the patient must be when the service is delivered are further detailed in the CMS's guidance but

[3] A question that APA Practice often receives from members regarding telehealth is whether it is appropriate to use Skype for communicating with and providing services to clients. Skype is a peer-to-peer voice-over-internet protocol (VOIP), which is "a technology that allows you to make voice calls using a broadband Internet connection instead of a regular (or analog) phone line" and "encrypts calls end-to-end, and stores user information in a decentralized fashion" (Federal Communications Commission, 2010). Skype appears to rely on user PCs to help carry voice communications. Although Skype purports to use Advanced Encryption Standard, or AES (which has been approved by the National Security Agency for encryption of top-secret information), there still appears to be a lack of consensus among both the provider and IT communities as to whether it is sufficiently secure for providing telehealth services. There are also other concerns about whether the transmission quality is adequate for telemental health services where visual and nonverbal cues are very important (Baset and Shulzrinne, 2004).

it is important to note that the patient's home is *not* an eligible setting (CMS, 2003). Additional CMS guidance lists the specific CPT codes (current procedural terminology) which are eligible for reimbursement for telehealth services, including many services typically provided by psychologists, and this list continues to evolve (CMS, 2011).

When submitting claims for telemedicine services, providers must use the appropriate telehealth modifier (GT) with the appropriate billing code (e.g., CPT or health care common procedure coding system [HCPCS]) for professional service. The GT modifier indicates "interactive audio and video telecommunications system" was used in providing the professional service. This modifier certifies that a Medicare beneficiary was present at an eligible originating site (located in either a non-MSA or rural HPSA) when the telemedicine service was provided. But CMS does not appear to specify what kind of audio–video technology must be used when furnishing telemedicine services (CMS, 2009). Under Medicare's current policies, psychologists are allowed to provide psychological services remotely to patients so long as the patient is a Medicare beneficiary, living in a rural HPSA or non-MSA area, and is receiving services at an approved site. This precludes the psychologist from providing services virtually to a patient at home or from using technology other than live audio-video communications (e.g., no emails, faxes, or phone calls).

As evidence of increasing support for telehealth services, CMS recently issued its final rule on telehealth credentialing and privileging. Instead of having to complete an often burdensome credentialing and privileging process for each health care provider who will consult remotely with a patient, hospitals may now implement a more streamlined process, accepting privileging by proxy. This means that a hospital may grant privileges to a telehealth provider at another hospital by accepting the privileging and credentialing decisions of the other hospital (Telemedicine Credentialing and Privileging, 2011). Therefore, a psychologist who is credentialed at a local hospital but not at the hospital where the patient is located may be privileged by proxy and thereby able to provide services remotely to the hospital patient. This recent change is important because the new rule reduces the administrative and financial burdens on hospitals for credentialing telehealth providers, such as psychologists, and would encourage those hospitals participating in Medicare and Medicaid to use telehealth services thereby potentially increasing the availability of services to hospital patients, including psychological services.

Medicaid

Medicaid is a joint federal-state program providing health care services to individuals and families with low incomes and limited resources. Medicaid programs are administered by the states, but federal law has established certain minimum requirements for states to follow in order to qualify for federal Medicaid funding. Because federal law is silent as to whether Medicaid reimbursement for telehealth is mandatory, states have the option to offer Medicaid reimbursement. CMS requires that states allowing Medicaid reimbursement for telehealth determine the scope of coverage that might include eligible providers and services as well as acceptable technologies or formats. Ultimately, states have the discretion whether to reimburse telehealth, so as a result Medicaid reimbursement can vary widely in terms of the types of services eligible for reimbursement, eligible distant providers, and payment methodologies. As many as 35 states allow for at least some reimbursement for telehealth services (Office for the Advancement of Telehealth, 2003). An area of expansion in Medicaid reimbursement is for *behavioral* telehealth. A 2003 survey conducted by a group at Boise State University, Idaho State University Institute of Rural Health, and the Idaho Division of Medicaid found that at that time only eight states reimbursed for telemental health services (Brown, 2006). A report from the American Telemedicine Association (ATA) suggests that reimbursement for psychological services using telehealth is now available in as many as 13 states under Medicaid: Alaska, Arizona, California, Colorado, Hawaii, Kansas, Maine, Michigan, Nebraska, North Carolina, Oklahoma, Utah, and Virginia (American Telemedicine Association, 2011; Center for Telehealth & E-Health Law, 2010; TeleHealth Connections for Children & Youth Project, 2005).

Nevertheless, it is incumbent upon psychologists who may be interested in providing psychological services using telehealth to Medicaid-eligible patients to contact their state Medicaid director to confirm whether telehealth reimbursement is available, whether psychologists are eligible to provide telehealth services and/or whether psychological services are covered, and what terms and conditions, if any, apply as well as what billing requirements exist for telehealth reimbursement.

Private Payers

While a significant percentage of telehealth reimbursement comes from public payers, telehealth reimbursement by private payers is a growing trend. To date, 12 states have enacted legislation requiring insurance companies to pay for services delivered through telehealth.[4] Several additional states allow for telehealth reimbursement under certain circumstances. Arizona and New Mexico allow for coverage of telehealth services but do not make reimbursement by private payers mandatory. North Dakota seems to allow for telehealth services in certain workers' compensation claims.

For those states with statutory telehealth reimbursement mandates, the relevant terms and conditions for reimbursement can vary. All 12 states mandate coverage of telehealth services by private payers if those health care services would otherwise be covered when provided face-to-face. However, very few of those statutes require that payers reimburse for telehealth services at the same rate as traditional face-to-face services. While only one state limits reimbursement to physicians, the other laws appear to include psychologists. Nevertheless, it is important to check your state law or contact your state insurance commissioner to confirm the scope and applicability of any such law.

It is difficult to determine accurately how many of the private insurance and managed care companies are reimbursing for telehealth services as special codes or CPT modifiers are often not used when billing for such services. A 2003 survey by the ATA and AMD Global Telemedicine identified 72 telehealth programs that provided billable telehealth services but only 38 programs in 25 states were receiving reimbursement from private payers. Sur-

[4] California, Colorado, Georgia, Hawai'i, Kentucky, Louisiana, Maine, New Hampshire, Oklahoma, Oregon, Texas, and Virginia.

vey findings also suggested that private payers tended to follow Blue Cross/Blue Shield (BC/BS) on the issue of telehealth reimbursement rather than Medicare. BC/BS was identified as reimbursing for telehealth services in 21 states. The survey also noted 100 other private payers were providing telehealth reimbursement (ATA & AMD Global Telemedicine, 2004).

Whitten and Buis (2007) conducted a survey to update the ATA/AMD findings. Of the 63 survey respondents providing billable telehealth services, 57% reported that they receive private payer reimbursement. The data noted approximately 130 private payers reimbursing for approximately 75 (unidentified) clinical specialty services. 81% of respondents reported very little difference in reimbursement rates (Whitten & Buis, 2007).

Psychologists who are interested in seeking private payer reimbursement for telehealth services should first determine whether there is a state reimbursement mandate and, if so, check with the state insurance commissioner as to the law's requirements. If no mandate exists, psychologists might consider contacting each payer directly about its telehealth reimbursement policies. The anecdotal data suggests that many payers are voluntarily covering telehealth and, in many instances, without any differences in reimbursement rates between telehealth and in-person services.

Psychology's Current Role in the Telehealth World

Currently, the APA has no official policy regarding psychology's role in telehealth. In 1997, the APA Ethics Committee issued a statement addressing psychological services provided by telephone, teleconferencing, and the Internet. That 1997 statement noted that the APA Ethics Code did not prohibit such practices and recommended that psychologists consider relevant ethical standards, such as boundaries of competence, informed consent, and confidentiality. However, that statement was based on the 1992 Ethics Code which has since been superseded by the 2003 Ethics Code.

Since then, APA has not issued any further guidance or clarification about how psychologists ought to proceed in using telehealth technologies for providing psychological services. There have been an increasing number of policy statements and guidelines developed by other professional health care organizations addressing the use of telehealth and/or electronic provision of services. Organizations such as the Ohio Psychological Association, Canadian Psychological Association, ATA, and the American Psychiatric Association have developed guidelines on the provision of telemental health services. Other organizations have addressed this issue as part of their ethical codes or in position statements.

With the rising increase in federal and state laws and regulations relating to delivery of telehealth services as well as the growth in telehealth reimbursement by private and public payers, there is a need for greater clarity and guidance on how the psychology practice community can safely and effectively use this technology to benefit patients.

In February 2011, the APA Council of Representatives directed the formation of a task force to develop guidance specific to psychologists on the use of telehealth technologies in providing psychological services. This task force, which will also include representation from ASPPB and the APA Insurance Trust (APAIT), is charged with evaluating ethical, legal, risk management, and practice issues (including licensure and interstate practice) arising out of telepsychological practice. The anticipated issues that the task force will explore will include current research on efficacy and cost-effectiveness in comparing telehealth to face-to-face interventions; licensure and mobility issues as well as interstate practice concerns; existing federal and state laws regulating telehealth practice; patient confidentiality, privacy, and security issues; and reimbursement.

At the same time, APA is continuing to host telehealth programming and workshops to educate members on research findings, current practice models, and legislative and regulatory policies. With a greater awareness about telehealth issues prompted by the APA-ASPPB-APAIT task force's work, the psychology community may approach this evolving practice area with greater confidence and understanding and use this technology to reach more patients and provide care more efficiently.

Conclusion

In light of the myriad federal and state laws and regulations, payer policies, technological challenges, and heightened privacy concerns triggered by telehealth practice, it can be a very confusing and challenging practice area for psychologists to navigate. This is particularly complicated as the most common practice, provision of services via telephone, is typically not addressed and often even excluded in laws, regulations, policies, and guidelines. Aside from a few states like California, Kentucky, or Vermont, most states do not have telehealth laws governing psychologists. Psychology licensing boards in several other states have considered the issue, and those board statements do offer some limited guidance for psychological practice.

Until the APA develops guidance for the psychology community, practicing psychologists must cobble together an understanding about the relevant laws regarding informed consent, patient confidentiality, privacy and security, and reimbursement to evaluate the benefits and risks—both to the psychologist and the patient—that telehealth might pose. This is in addition to the competency that the psychologist ought to attain in using the technology itself and in understanding when and for whom electronic-based interventions would be appropriate.

Nevertheless, the world of telehealth is moving forward, spurred in part by the push toward adoption of electronic health records and health information technology. As a result, it appears to be inevitable that psychologists will be confronted with situations where they may need to use technology with some of their patients. A better understanding of the common issues that psychologists might encounter with using technology may strengthen the provision of quality services.

References

American Psychological Association Practice Organization. (2010). Telehealth: Legal basics for psychologists. *Good Practice, 41,* 2–7.

American Telemedicine Association. (2011). State telemedicine policy center. Retrieved from http://www.americantelemed.org/i4a/pp./index.cfm?pageID=3604

American Telemedicine Association & A. M. D. Global Telemedicine. (2004). Private payer reimbursement information directory. Retrieved from http://www.amdtelemedicine.com/telemedicine-resources/private_payer.html

Arizona's Telemedicine Statute, 36 Ariz. Rev. Stat. § 36–3601 et seq. (2004).

Baset, S. A., & Schulzrinne, H. (2004). An analysis of the Skype peer-to-peer internet telephony protocol. New York, NY: Columbia University, Department of Computer Science.

Brown, N. A. (2006). State Medicaid and private payer reimbursement for telemedicine: An overview. *Journal of Telemedicine and Telecare, 12,* 32–39.

Center for Medicare and Medicaid Services. (2003). Carriers manual Pt. 3 - Claims process. Retrieved from https://www.cms.gov/Transmittals/Downloads/R1798B3.pdf

Center for Medicare and Medicaid Services. (2009). Telehealth services fact sheet. Retrieved from http://www.telemedicine.com/pdfs/TelehealthSrvcsfctsht.pdf

Center for Medicare and Medicaid Services. (2011). Physicians/nonphysician practitioner. In *Medicare claims processing manual* (12). Retrieved from http://www.cms.gov/manuals/downloads/clm104c12.pdf

Center for Telehealth & E-Health Law. (2010). Reimbursement overview. Retrieved from http://www.ctel.org/expertise/reimbursement/reimbursement-overview/ Code of Federal Regulations, 42 C. F. R § 482, 485 (2010).

Eder-Van Hook, J., Burgiss, S. G., & Waters, R. J. (2006). *Medicaid policies on telehealth services: A comparative analysis*. Washington, DC: Center for Telehealth & E-Health Law.

Federal Communications Commission. (2010). Voice-over-internet protocol frequently asked questions. Retrieved from http://www.fcc.gov/voip/

Fleischer, L. D., & Dechene, J. C. (2010). *Telemedicine and e-health law*. New York, NY: Law Journal Press.

Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104–191, 104 Cong. (1996). Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/ administrative/statute/hipaastatutepdf .pdf

HIPAA Administrative Simplification Rules. 45 C. F. R. pt. 160, 162, 164. (2003). Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/administrative/index.html

Johnson, J., & Bendixen, R. (2005). Telehealth. In W. C. Mann (Ed.), *Smart technology for aging, disability, and independence: The state of the science* (pp. 207–208). Hoboken, NJ: Wiley.

Kentucky's Telehealth and Telepsychology Regulation, 201 Ky. Admin. Regs. § 26–310 (2011).

Kentucky's Telepsychology Statute, Ky. Rev. Stat. Ann. 26 § 319–140 (2000).

Kumekawa, J. (2001). Health information privacy protection: Crisis or common sense? *Online Journal of Issues in Nursing, 6.* Retrieved from www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableOfContents/Volume62001/No3Sept01/PrivacyProtectionCrisis.aspx

Massachusetts Board of Registration of Psychologists. (March 2006). *Provision of Services Via Electronic Mean.* Retrieved from http://www.mass.gov/?pageID=ocaterminal&L=6&L0=Home&L1=Licensee&L2=Division+of+Professional+Licensure+Boards&L3=Board+of+Registration+of+Psychologists&L4=Statutes+and+Regulations&L5=Board+Policies+and+Guidelines&sid=Eoca&b=terminalcontent&f=dpl_boards_py_policy_electronic_services&csid=Eoca

Medicare and Medicaid Programs: Changes Affecting Hospital and Critical Access Hospital Conditions of Participation: Telemedicine Credentialing and Privileging, 76 Federal Register 25550 (2011) (to be codified at 42 CFR Part 482, 485).

Milby, S. (2010). The new meaning of a house call: Wanna Skype, Dr. Gupta? NewBizViews. Retrieved from http://www.newbizviews.com/2010/04/12/the-new- meaning-of-a-house-call-wanna-skype-dr-gupta/

North Carolina Psychology Board. (March 2005). *Provision of Services Via Electronic Means.* Retrieved from http://ncpsychologyboard.org/office/ElectronicServices.htm

Office for the Advancement of Telehealth. (2003). *Telemedicine reimbursement report* (Contract #02-HAB-A215304). Retrieved from ftp://ftp.hrsa.gov/telehealth/licen.pdf

Oklahoma Telemedicine Act, OK. St. Ann. § 36–6801 et seq. (1997).

TeleHealth Connections for Children and Youth Project. (2005). *Telemedicine for CSHCN: A state-by-state comparison of Medicaid reimbursement policies and Title V activities.* Gainesville, FL: University of Florida, Institute for Child Health Policy. Retrieved from http://www.ichp.ufl.edu/documents/Telemedicine%20in%20Medicaid%20and%20Title%20V%20Report.pdf

Telemedicine Development Act of 1996, Cal. Bus. & Prof. Code § 2290.5 (1996).

Texas State Board of Examiners of Psychologists. (December 1999). *Telepractice Policy Statement.* Retrieved from http://www.tsbep.state.tx.us/newsletter_12_2.html

U.S. Department of Health and Human Services & The Office for Civil Rights. (2010). Health information privacy security rule frequently asked questions. Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/faq/; http://www.hhs.gov/ocr/privacy/hipaa/faq/securityrule/index.html

U.S. Department of Health and Human Services & The Office of the National Coordinator. (2008). The nationwide privacy and security framework for electronic exchange of individually identifiable health information: Privacy and security framework safeguards principle and FAQs. Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/healthit/index.html

Vermont's Telepractice Regulation, 26 Vt. Stat. Ann. § 3018 (1999).

Whitten, P., & Buis, L. (2007). Private payer reimbursement for telemedicine services in the United States. *Telemedicine Journal E-Health, 13,* 15–23.

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