[Jewel Edwards-Ashman] Okay, hi -- good afternoon, everyone, and welcome to today's webinar: Practicing telepsychology -- what is legal and what is not. This webinar is brought to you by the APA Practice Organization, a legally separate companion organization to the American Psychological Association; the Practice Organization advocates for psychologists on reimbursement issues. I'm Jewel Edwards-Ashman and I'll be moderating today's webinar and I'm happy to welcome today's presenters. We have Deborah Baker; she's director of legal and regulatory policy here at the Practice Organization and she's joined today by Dr. Alex Siegel, who is director of professional affairs at the Association of State and Provincial Psychology Boards, also known as ASPPB. Just a reminder that everyone attending this webinar will be in listen-only mode, so if you have a question please type it into the chat box. You can also email your question to practice at APA dot org and our presenters will address many of your questions that were submitted in advance and those asked here on the air at the end of their presentation. Please note that this webinar is being recorded and we will email you a link to the recording within a few days. So, I'm now going to turn this webinar over to Deborah Baker.

[Deborah Baker] Thank you, let's see… can we switch it? Okay. Okay. So, today I would like to talk to you about some of the legal and ethical issues that you encounter in dealing with telepsychology or telehealth. The number of member calls that we receive regarding questions about telehealth have been increasing exponentially over the past couple of years and what seemingly seemed… comes across as a simple question of "May I Skype with my patient?" often to our members' surprise turns into a more in-depth conversation about a variety of issues implicated when engaging in telepractice and the issues are described here on this slide. What is telehealth or telepsychology and the reason for noting that will be important as we continue with our… this presentation. What are the best practice considerations and those… a lot of those are highlighted in the APA Guidelines for the Practice of Telepsychology. Are there specific privacy and security issues? Often those are aligned with HIPAA and high-tech requirements, but there are some that exist, even if you aren't required to comply with HIPAA, and then also insurance: is the patient using any third-party payer or coverage benefits for those services and what are the requirements by the third-party payer? And then also are there specific considerations when you're talking about telepractice within your state versus practice when the patient is in another state – in particular a state where you're not licensed – and that'll definitely be discussed in more detail by Dr. Siegel in his presentation.

So, first of all why is the definition important? Well, there is no one universal definition of tele… telehealth or, more specifically, telepsychology and the definition can vary in two respects. First of all, what kinds of technology are covered in the definition; is it very exclusive and applies only to audio video conferencing or is it more expansive to include other modalities such as email, chats, and other types of platforms? And then what are the uses that are contemplated by the definition? Is it limited just to the delivery of clinical services or is it a broader definition that may also include patient management, consultation with caregivers, or even provider education? So, it's really important to note how that term is defined in the context in which you're looking at the issue. So APA had convened an inter-organizational taskforce in 2011 and comprised of 10 persons -- four of whom represented APA. There were four representatives from ASPPB and two from the Trust to develop practice guidelines to better educate and guide psychologists in this new space. And one issue that the taskforce struggled with was how to define the term and the taskforce decided after reviewing the available literature and looking at how other organizations and other agencies defined the term that it wasn't going to specify a particular type of technology, understanding that technology is evolving at a very rapid clip outpacing developments in the in the legal and regulatory space and then it made a deliberate choice to be expansive in the definition it uses. So here in this slide you'll see how the term "telepsychology" is defined in the guidelines and it includes phone in addition to video conferencing, emailing, chatting, texting, the different internet-based platforms and the and the purpose of the task force's goal was to identify aspects engaging in telepractice that are unique or different from providing those same services in person.

So the telepsychology practice guidelines focus on eight principles. First and foremost, those principles focus on the psychologist's own knowledge of and competence in providing psychological services through electronic means and implicated in that is understanding or evaluating the patient's own competence. Is the patient clinically, cognitively, and technically appropriate to participate in telepsychology? You're going to find on an individual basis, some patients are going to be more appropriate for engaging in telepractice than others and so that's an ongoing evaluation that needs to be made. Also understanding… also making sure that the patient understands the potential increased risks to his or her confidential information; for example, a practical consideration is when a person comes into your office to meet with you, you control the environment to ensure that it's quiet, private, and free of distractions. But if a patient is in another location, do you ensure as part of the informed consent discussion that the patient understands the importance of being in an environment that is free of distractions, quiet, does not have family members or other persons kind of walking through or in the room without the knowledge of you as the psychologist. And then also understanding whether you keep your patient's information in paper or electronic form: are you protecting that in an appropriate way, particularly the electronic information? For example, you know, do you record your sessions and, if so, does the patient know about it? How do you store it? If there's any kind of electronic communications otherwise, how do you store those? How are those transmitted and… and, even more importantly too, is down the road, how do you dispose of any of that data or any of the devices that you use for transmitting and storing data?

The final principle under the guidelines is the interstate practice issue and, at the time that the task force was work… developing the guidelines, it recognized that there is no clear legal mechanism that allows psychologists to practice across state lines into another state where he or she may not have a license. Some states do have in the Psychology Practice Act or its accompanying rules, a temporary practice provision that typically allows an out-of-state licensed psychologist to practice temporarily in to the state without obtaining a license, but not all states have this provision and in… in those states that do, there's a lot of variability both in terms of the duration in which you could practice temporarily. Some states it's very few days like six days in a calendar year; some states can be up to 30 days. And then there's also variability in terms of how do you… how do you avail yourself of the provision? Some states let you do it on the honor system of sorts where some states required the psychologists – the out-of-state psychologist – to obtain advance approval from that licensing board before they can begin practicing into that state. And because of this great variability among states, it creates a lot of confusing onerous burden on the individual psychologist to navigate and understand what the various states' requirements are. So because of this, without having a very clear legal path, the most that the guideline could do at the time is advise the psychologists to be familiar with the requirements and the policies of the state where the patient is at the time that telehealth services are rendered. And another point to think about – which I'm sure Dr. Siegel is going to address – is beyond the licensing requirement issue is also understanding what happened when… when there is a conflict of laws. So if you're in one state that has a duty to warn or duty to protect requirement, but the other state does not, which state law do you follow and then are you in breach of the other state's law? Whichever state law you followed, do you risk breaching the other state's requirements? And then some states have specific policies either in the state licensing law, the rules, or a board may have issued an advisory opinion that requires any services provided by electronic means to consumers in that state be provided by a provider who's licensed in that state, just as if those services are provided in person. And so then the question becomes how does that policy match up with the temporary practice provision, if such a provision exists at the state level?

So an issue that we've kind of touched on in the previous slide is talking about HIPAA HITECH compliance. Just a reminder that if for some reason you are transmitting electronic patient health information – for example, through an insurance claims submission – that triggers HIPAA, requiring you to be compliant not just for that particular patient, but for your entire practice. and so when you're engaging in telepractice and using technology, you need to be mindful of any requirements that HIPAA or HITECH may impose both under the privacy rule as well as the security rule and specifically thinking about electronic patient health information

whether it's communications via email, for example, or there's a video conferencing interaction you need to be aware of “how am I protecting that electronic data?” and it can come in several different ways. There can be physical safeguards whether you're talking about paper files or electronic files. How are those stored? How are these maintained? How are those accessed? Just as if you would have paper files locked in a file cabinet that may be locked in a particular office or storage room which only certain people have access to, that same kind of thinking would apply to any kind of software or particular devices that may have patient information. Thinking about if you’re a solo practitioner: is this a device that has patient health information on it and, if so, is this something I use both for personal purposes and professional purposes and does anyone else have access to it? So how am I locking it or keeping safeguards in place to ensure other people can't access it inappropriately? The same thing with technical safeguards is making sure do you have password protection on either the entire device or certain portions of the device, particularly where the files may be stored. Do you use encryption for email? While it's not necessarily required, it is a gold standard that would be a good defense if for some reason there was a data of any patient health information… I mean, breach of patient health data. Also, you know, do you segregate your… your data? So, for example, if you do have a small practice where other folks may have access to certain patient health information – for example, for scheduling or for billing purposes – do they necessarily have access to the patient records? If you… in terms of notes or other kind of confidential information that that staff person doesn't need to need as part of their role in the practice. What about maintaining virus and malware protection on the device is used to that store, transmit electronic patient data? And then when you're no longer using particular devices, whether it's desktop, laptop, external hard drives, thumb drives: how do you dispose of those appropriately? And it also thinks about… think about using Wi-Fi. If you're in a public Wi-Fi network, that may not be a very secure way to transmit data. Are you using it on a private secured Wi-Fi? In addition, if you're using third parties such as video conferencing platforms, do you have business associate agreements which is required for third parties who may have access to your patients’ health data in their role helping you run your practice? So that's not only just video conferencing platforms; that could be if you're using billing software, a billing management company, or if you're working with an accountant or an attorney as part of your practice. And it's…let me back up; I do mention when I talk about HIPAA-compliant vendors and video conferencing, I tend to discourage folks from necessarily using the free platforms like Skype or Facetime if you can't have assurance that it is HIPAA compliant and have a business associate agreement on hand, either available through the vendor or a willingness by the vendor to sign one that you supply.

So let's move to the issue of payers. If you have a patient who will be using insurance benefits to cover those services being provided through technology, you need to understand if the payer has policies and, if so, what they are. So CMS does cover most psychological services that are provided via telehealth; however, CMS does have specific restrictions. It includes limits to beneficiaries being in health shortage professional areas, typically rural or medically underserved areas and the patient has to be in a clinical setting. So if a patient is not in a professional shortage area and is not in either a provider’s office, a hospital, skilled nursing facility, etcetera, you cannot provide telehealth services to that Medicare beneficiary. So you cannot Skype with the patient in his or her home under Medicare's policies and it has to be videoconferencing, so phone therapy would not apply here. There are no separate CPT codes for telehealth services. You typically use the CPT code that best describes the service provided and you use the GT modifier to signal that that was provided by a technology or videoconferencing, as opposed to an in-person office visit. Medicaid is probably by far the biggest payer of telehealth at this point; all 50 state Medicaid programs have some sort of coverage for telemental health services, including therapy, mental health assessments, and the diagnostic interview exam. Medication management is also covered, but obviously that's being provided by physician or psychiatric nurse practitioner. Private payers are increasingly more receptive to covering telehealth, so it's important to understand what the insurance company's policies are about coverage, and here you'll see in this map this signals or demonstrates the number of states that now have enacted insurance mandates. Thirty-five states plus the District of Columbia have mandates that prohibit insurance companies from denying services or denying to coverage of services simply because their services are provided by telehealth if those same services… services would be covered if

provided in person. So there are several states that are still in blue; those are states have not enacted such a mandate yet. North Dakota…. actually North Dakota needs to be changed because they just changed it. Illinois and Massachusetts is… is optional in terms of this; those two states laws do not require coverage. Instead it says if an insurance company chooses to cover telehealth services, it cannot put any restrictions on telehealth in terms of requiring initial in-person contact or limiting settings where telepractice services can be provided. So… and then Louisiana at this point only limits coverage to physician services but all of the other orange states, including North Dakota which needs to be changed, covers the services if they're… if they're covered as an in-person service, they'll be covered as a telehealth service. What's important to note is that the devil is in the details. First of all, are they as we mentioned… are they require… is the insurance company required to provide it or is a discretionary? Right now it's discretionary in Illinois and Massachusetts. Another issue to think about is does the law require reimbursement to be at the same level as in-person service; that's not the case in all of those states' laws. Does the mandate apply to all insurance plans? In some states it's just private health insurance it doesn't necessary include state employee health plans or self-insured plans, so it's important to check what your state's law says. Can the insurance company limit coverage to services provided by its in-network providers? For example, Massachusetts does have that option, so if you're an out-of-network provider you couldn't… you couldn't argue that your services would be covered under this state law. Are there any geographic restrictions? Arizona and Colorado used to limit it to rural areas, but they have since amended their state laws and… and done away with the geographical limitations and then again look at the definition of telehealth. Is it expansive? A lot of states exclude phone, email, and fax in the definition, meaning an insurance company does not have to cover it under this law if you provided phone therapy versus providing services via videoconferencing. So it's important to look at how the state mandate defines telehealth to understand what technology modalities you can use. And so it's important also to note that these state mandates do not extend to federal programs like Medicare. And so now I'd like to turn over the presentation to Dr. Siegel to talk to more about the interstate practice considerations.

[Alex Siegel] Thank you very much. Okay, hi everyone -- I'm Alex Siegel; I work with the Association of State Provincial Psychology Boards or ASPPB. I'm going to talk rather fast because I have a whole lot of information that I want to give; for some reason, I thought I had 40 minutes but I only had 20 minutes and if you have any questions, please feel free either to type them in or if afterwards my email will be the last slide, please feel free to email them to me. What I'd like to kind of present today is tell you what the state of the art is now, what ASPPB is helping to kind of change in developing a compact – which is really a contract between states, and what a compact or PSYPACT will allow individuals to do as it becomes operational and now I'll tell you where we are in that process. So for those of you who do not know about ASPPB, we're an organization made up of 64 jurisdictions in the United States and Canada; we help the individual states, provinces, and territories… help them regulate the practice of psychology. We've been around since 1960, trying to deal with mobility and portability issues; we're reducing barriers for licensure portability as well as helping states and provinces and territories develop standards for licensing. All of you probably at one time or other took the E Triple P exam that you need to take in order to become licensed; ASPPB produces that exam. So that's who we are and what we do; let me tell you quickly about the state of art and I'm going to pick up a little bit from what Deborah Baker said earlier. Right now, it's really like the Wild West out there. If you're wanting to provide electronic services for a patient of yours in a different jurisdiction, you need to talk to that jurisdiction to find out what limitations or what allowances they will have for you to provide services to that person. Some states don't have anything, so that if you were to electronically see someone in that jurisdiction, technically you're practicing into that jurisdiction without a license and could be subject to disciplinary procedure.

So let me kind of focus a little bit about an example. Suppose I'm seeing a patient of mine (I live in Pennsylvania) – I'm seeing a patient in Philadelphia in my office, which is fine. I'm licensed here; the patients in my office – no problem. Now my patient decides as she does every year to go to Florida during the wintertime and she'd like to touch base with me periodically and have an electronic session in Florida. Right now, if I were to do that since

I'm not licensed in Florida, I would be violating Florida law by electronically working with that patient while she's in Florida. If, for some reason, I went down there for a vacation or for a meeting and I'm in Florida and I… and my patient said, “Hey, you're in Florida; we’re near enough -- let's have a session.” Not obviously in her house, but if I had a colleague and I could rent office space for an hour or so, I could… could I see the person in that office. It’s a Pennsylvania psychologist seeing a Pennsylvania patient in the state of Florida. So Florida is concerned only about protecting the citizens of their… of their state because that's what the charge of licensing boards is. So, however, in this situation Florida would say, “Well, even though it's a Pennsylvania psychologist working with a Pennsylvania patient, you're in the state of Florida. You’re not licensed to write any services here; you would be violating our law and therefore we could start disciplinary action against you.” And that's also true if I'm seeing a patient who's a student who goes off to another state to go to college and wants to continue with me electronically; depending on the state, I may not be allowed to do that. Some states will allow you to do that based on temporary procedure. The next question becomes “Well, what laws do you follow?” and Deborah Baker kind of talked about that. Let me kind of give you a concrete example here. I'm in Pennsylvania where the law says for duty to warn if a patient tells me they're going to hurt themselves; I'm obligated to use reasonable care to protect by warning that individual. Now suppose my patient is in Texas; Texas doesn't have a mandated reporting criteria. The patient tells me electronically that they're going to kill their next door neighbor; if I report it, I just violated Texas confidentiality. If I don't report it, Pennsylvania is going to say that I violated the duty to warn standard and so the question becomes which state has jurisdiction to handle the matter. And the state of the art now is no one knows because Pennsylvania could easily say, “Well, we don't have any control over here because it's not a citizen of the Commonwealth of Pennsylvania; they’re in Texas” and Texas could clearly say, “Hey, this person is not licensed in Texas, so we don't have any jurisdiction over the matter” and nothing happens and the protect… public is not protected. The same thing is true with duty to protect… excuse me… child abuse reporting laws. So, for example, if you make a good-faith report within your jurisdiction about someone who may have harmed a minor and met the criteria for mandated child abuse reporting, there's limited immunity. As long as it's a good-faith attempt, you have immunity and can't be prosecuted for making that report; however, if you're doing this electronically over into a different jurisdiction, immunity doesn't follow you into that other jurisdiction. So, if you were to report child abuse in that other jurisdiction and there was a hearing and that hearing found out that that was unfounded, that there was no child abuse after children and youth or whomever adjudicated the case, that patient now can sue you for breach of confidentiality, defamation of character, libel, slander depending on how you've done that, and the immunity will not protect you from that.

So what… what's PSYPACT? The psychology interjurisdictional compact or PSYPACT. What that is… is a mechanism to allow for states to work together to kind of resolve the differences in practice issues and to allow for one psychologist to see someone electronically into another state without being licensed there and I'll talk about that more in a minute, but so a compact basically is a contract, or treaty if you will, between states. It’s an effective way of addressing common problems, economies of scales. Medicine has a compact; nursing has a compact; and if you think about compacts, legislators really understand compacts. Think about the driver's license compact. You have a driver's license in your state and you can drive anywhere else in the United States without being licensed someplace else. The downside to that is in 44 of those 50 states, if you were speeding and you got arrested and you got points, those points are going to come back to your initial state and that initial state can use those to discipline you, if you will, or make you go to driver's ed classes or something. So people…legislators understand it. as I also mentioned earlier that ASPBB is made up of the United States and Canada; however, the compact is just for the United States and not Canada because if we wanted to do this both the United States and Canada, it no longer becomes a compact – it becomes a treaty and then with a treaty you need to have consent of the Senate and signed off by the president and given the states’ rights issues today and what's going on in Washington, that's never going to happen anytime soon in my opinion.

So here's what PSYPACT does: it does two things. One is if you… if your state adopts PSYPACT and it's a legislative action and you apply for a e-passport -- we'll talk about that in a minute -- you can then electronically see someone from Pennsylvania (in my case) into any other compact state without being licensed in that compact state. So, in my first example about Pennsylvania and Texas, if both are compact states, I could see the patient into Texas and I don't need to get licensed in Texas; I don't need to pay Texas licensing fees or their CE requirements or their administrative costs or whatever. That's part of the compact and that's unlimited and this is so. And the second thing is temporary, in-person face-to-face for up to 30 days; so, if I'm in Pennsylvania and a patient from New Jersey crosses the river and comes to see me in my office, that's fine because I'm practicing in Pennsylvania; they're in Pennsylvania -- it's not a problem. If the person… I'm working with an autistic child, for example, and the parents want me to go to the school to help develop the IEP or to do behavioral observations of the child or work with the teachers, right now I can't do that because I'm not licensed in New Jersey to set foot in there and to see that child in that setting. However, the compact would afford me the opportunity to go into New Jersey for that's a compact state and to do an evaluation there under the auspices of the compact. It's also good for industrial/organizational consults, forensic evaluations, but it's not intended as an end around a licensure so it's limited to 30 days and one minute equals one day so you can't say, "You know I think I'll go and set up shop for… for the Mondays. Every Monday I'll open up an office and I'll just take off the holidays in the summer, so I'll have a part-time full-time practice in that state." It's not intended for that and that would be a violation of the compact.

So, how does a compact work? It forces states to work together to exchange information from disciplinary stuff, from licensure stuff, and it also will afford the opportunity, once the PSYPACT is operational, a commission will be set up to develop the bylaws and to help regulate the day-to-day practice of the compact. There'll be one member from each compact state which will make up the commission and you need to have seven states to do that and we'll talk about where we are in the process in a minute. And once we have seven states, then it becomes operational. Psychologists who want to participate to provide services under the auspices of PSYPACT will need to apply for the e-passport and then the IPC. And the reason why that is… is since you're going to be practicing into another state without being licensed, that state wants to have some type of assurances that you know what you're doing; you're competent; you understand IT stuff. No one wants you to be an IT expert, which you at least need to know that Skype isn't HIPAA compliant and if you're using that as a vehicle to provide the services, you are violating HIPAA and potentially any state law that has adopted that. So the e-passport creates a relationship between the psychologist, the home state, and the receiving state to kind of work out those issues in terms of differences of law. The compact affords the opportunity that where the psychologist is licensed and providing services will take priority. So in my Pennsylvania case about duty to warn, Pennsylvania law will take precedent over Texas law, but you also need to -- under the doctrine of informed consent -- have that discussion with the patient at the beginning of the process by saying, "If you were to say that you were going to harm someone else -- even though Texas law says I'm not going to do that – under Pennsylvania law and under the compact, this is how we're going to proceed." the patient has the authority and the ability to say, "I agree to that" or "I don't agree to that; I'll find someone else", but that's how informed consent kind of plays with this process. So ASPPB will then vet folks to make sure that they meet their criteria for the passport. You need to have a graduate degree in psychology with the education, experience, and residency; you have to have a full and unrestricted license. You can't have any adverse action on your licensure; you can't have any criminal history; you can't have any child abuse; you need to have an e-passport and more… and you also need to… make certain attestations of where you're intending to work, who your types of individuals you're qualified to see, what's your experience here, and to sign releases so that jurisdictions will be able to kind of talk between each other to kind of allow ASPPB to primary source-verify that. And the commission then could also add additional criteria as they see fit as things are kind of worked out. So this will hopefully assure states that you're practicing into that you meet some type of minimum qualifications and competency to be able to provide those services into that state without being licensed.

So this is a design about how it works; it's a hub-and-spoke model. From one compact state, you can see patients all over the place from compact to compact. The example that I like to use is right now there's one very well-known forensic psychologist who is an expert in death penalty cases and intellectual disability. He testifies all over the country; he's licensed in 26 or 27 states. He has a full-time secretary just to keep up with when his CEs are due, when he has to renew his license, and so forth. That's not a tenable for the average psychologist that may see one person in Montana, one person in Arizona, so this is kind of a compromise to assure licensing boards they can protect the public and assure psychologists that they can provide those services to those individuals that may not be receiving those services in that state.

The IPC is similar, but this is pertaining to the temporary face-to-face in-person into the other jurisdiction for up to 30 days. It’s just a different certificate that you would need to provide that; it's based on similar criteria.

So the benefits of PSYPACT is increases patient care, facilitates continuity of care when patient relocates or travels or temporary moves, or if you want to follow a college student when they go to a different place. It certifies that psychologists meet certain standards, allows states to cooperate in the licensure and regulations between the compacts. It holds licensees accountable and increases consumer protection and, most importantly in my opinion, it promotes the ethical and legal interjurisdictional practice. We know right now that, as I said, it's a Wild West out there. If you go check a site called Talk Space, they claim they have two to three thousand therapists that are providing services and five hundred thousand people that use those services. In their… in their contract, according to an article that I read, the psychologist does not know who the patient is; they only know their sign-in name. They don't know who the actual person is, where they are, what's going on -- so what would happen if a psychologist was working with that patient and that patient says, “You know last week I was drunk and I had both of my two-year-old kids in the back seat of the car and I almost got in an accident.” Some states – that's reportable, but if you don't know who that person is or where they are, how are you going to make that report? And now are you putting that psychologist in jeopardy and, more importantly, those kids in jeopardy? PSYPACT allows for consumer protection and also accountability of psychologists.

The difficulty with PSYPACT is you have to write laws so that it's general enough, but specific enough because once you adopt it, you can't change it. So, for example if we were to have this five or ten years ago and put in the word MySpace as that's the only modality that you could use to provide services – and obviously MySpace really isn't around anymore – if it was in the compact, that would be the only mechanism that you could use to provide for the interjurisdictional practice. So you have to write it so that you need to kind of think how the field is going to evolve in the future. You also want to make it the bar not too low or too high – like Goldilocks and the three bears – but you have to figure out the sweet spot so most people can get into it, but you're also putting up mechanisms so that the unscrupulous or unethical psychologists would not be able to provide services under this.

So here… here we are; this is a map of where we are. Currently we have three states that have adopted PSYPACT: that being Arizona, Utah, and Nevada in blue. We almost had Missouri, but went down in defeat due to a procedural… procedural vote, or the procedural non-vote. We had the votes in the house, in the senate in Missouri, but because of a filibuster, that was never brought up. Illinois is… has active legislation as well as Rhode Island currently and we’re anticipating that with Texas sunset that PSYPACT is part of that process. And in Wisconsin as they work through their updating their model act, there's talk about introducing a companion bill or separate bill for PSYPACT.

So we think we're in good shape this year. Here are… that's just kind of… I defined what was in the thing. Here’s some states that have asked for presentations or information about PSYPACT; some of the asterisks are states that are interested in thinking about introducing PSYPACT legislation in 2018, so we're real optimistic that by the end of 2018, we'll have the seven states and PSYPACT will become operational. Here, PSYPACT has its own web

page; we have a Twitter account. If you want more information about PSYPACT, please feel free to check it out. There's the actual text of the PSYPACT, questions, and – more importantly – if you go to that website and indicate that you're interested in this and you'd like to kind of help with the process as it goes through legislative process in your state, we may need psychologists to kind of write their legislators and telling them why this would be a real benefit to you as a psychologist and more importantly to the consumer to get services that they may not be receiving.

And this last slide is my contact information. Janet Orwig is… will be the… is heading PSYPACT for ASPPB and Lisa Russo is one of the staff members who's also working with it and any one of us will be more than happy to answer any questions you have about PSYPACT. I thank you very much; it went over by three minutes and I apologize.

[Jewel Edwards-Ashman] That's… that's okay, Alex; thank you so much, Deborah and Alex, for your presentations. This is Jewel again and we got a lot of questions, so we're just going to dive right in. A bunch of psychologists have asked about… asked if you guys could give a few examples of video conferencing platforms, online apps, telecommunication platforms, and telepsychology software that are HIPAA-compliant. Do you have any examples of those?

[Deborah Baker] So, I always have to issue the disclaimer that APA does not endorse or in any way, you know, have a formal approval process for any of these types of platforms. So when I throw some of these out, these are some platforms that I have found when I've attended the American Telemedicine Association conference because they have a huge exhibition hall that these platforms seem to hit the two… the two high points that I mentioned, which is not only do they need to claim their HIPAA compliant, but they need to demonstrate it in their policies and which should include the willingness to execute a business associate agreement – which you know indicates that they understand really what HIPAA compliance means. So there's some out there; Zoom is… is one I've seen occupying the space for a while; VSee -- so it's the letter V-S-E-E dot com has been in that space. We Counsel: W-E-C-O-U-N-S-E-L dot com. I think there's HIPAA Chat; Cloud Visit TM – C-L-O-U-D-V-I-S-T-T-M dot com. I'm sure there's some other ones I'm not thinking of at the moment, but these are platforms I encourage members to kind of stop thinking about Skype or necessarily FaceTime and look at these platforms that are purposely marketing towards HIPAA, towards health care providers, understanding that HIPAA is a specific concern that… that providers need you to abide by and so look for those things. And then understand too that the whistles and bells that may come with it are going to vary by site and also by the pricing plan. Some of them have an as-you-use-it, like, per session charge; some of them may say if you're only using it under five times a month that we'll offer it for free, but you still want to make sure you understand whether or not the… how they keep their information, best of all through a business associate agreement. So go test-drive them; you can always schedule an appointment with their… their team to kind of walk you through what you would see from the provider side versus the patient side and just ask the questions. What's the customer service if you have a technical glitch? What happens, you know, in the middle of the session? Do they have… do they have a secure portal so that you don't have to worry about what email service you're using? You know… you know you don't necessarily just want to use your personal Gmail account. Do they have a portal that you can then message with your patients that you know is secured and encrypted in the transmission? So those are things to think about when you look at some of those sites that you wouldn't necessarily get through FaceTime or Skype.

[Jewel Edwards-Ashman] Okay, great – thank you. We also got a couple of questions about the billing the modifier code. Some people were asking if it's minus 95 versus GT and you know I'm not knowledgeable on that, so maybe you could clarify that for some of our listeners.

[Deborah Baker] I'm sorry I didn't understand the question; what was the other modifier other than GT?

[Jewel Edwards-Ashman] They want to… they would like for you guys to confirm that the billing… that for billing, the modifier code is minus 95?

[Deborah Baker] I can't answer that; I mean, I would have to… I would have to refer to our Office of Health Care Financing, but you can always ask the individual payer as to how they want that noted in the billing or claim submission

[Jewel Edwards-Ashman] OK, great -- we got a couple of questions from people who were saying they might be moving overseas or their clients might be moving overseas; can they still provide telehealth services to them? Is that legal/ethical?

[Alex Siegel] So let me answer that in two ways. First it's a risk management question that I would, for those individuals that have that concern, I would talk to your insurance carrier to see what their opinion is. Having said that, just like practicing between the states, it depends on what country, where you are, what's going on. ASPPB is…. I'm going to be on a flight tonight to Amsterdam to go to the European Congress meetings and on Saturday I'm meeting with the ESPA people and being a liaison to their Commission on telehealth because the Europeans are trying to figure out how they can provide services among the 32 states of the ESPA association. ASPPB has also had meetings with the Australians and New Zealand to kind of also try to provide that service. So, technically, legally it may be unethical and/or illegal to provide services into another country. I would contact those colleges or regulatory bodies in those other countries to find out how they perceive that and whether it's permissible or not, but it all depends. So, we… ASPPB is kind of working with other states in other countries to kind of figure out how we can all play nice together in the sandbox and to provide legal and ethical electronic communications between individuals in different countries.

[Jewel Edwards-Ashman] Okay, thanks. We also had a question about PSYPACT, specifically relating to the slide where you showed the map of the different states that were highlighted in orange. Someone asked do the states in orange… are they not limiting telehealth to clinical settings? Can you provide telehealth in a client's home? So, if you could just clarify what the states in orange when it relates to PSYPACT what… what that means.

[Alex Siegel] So the states in orange means that the licensing board believes that PSYPACT is a great idea and would not oppose that legislation it were… if it were to be adopted. However, PSYPACT needs to… is a legislative act to… action, that it needs to be a separate bill introduced into the House and the Senate or the representatives of that state and signed by that governor before it's adopted. So, the orange states – the boards are in favor of it, but there they… they don't have the authority to override state government and you also have to think… think about also with… so let me back up. ASPPB doesn't get involved in the intrajurisdictional because we believe that's up to the states. We're kind of looking at the inter process: how we could work better together. So, for example, in New Jersey unless a law has passed within the last three or four months, you can't provide telepsychological services within New Jersey. Pennsylvania, on the other hand, the board looked at that when I was on the board and said that it's no different than providing services as you would in an office; so you could use telepsych services within the Commonwealth of Pennsylvania. It also depends if you're outside of Medicare. You may be able to provide services into an individual's house, but if you're using Medicare, you would not be able to because Medicare doesn't allow that. So, it really is state-specific and I would talk with those individual states as to what you can't… what they say you can and cannot do. PSYPACT will allow you to see people into their individual houses from your house to their house or from your office to another office, so it's a lot wider than the Medicare restrictions.

[Jewel Edwards-Ashman] And while you have it up, Alex, I think there was another map of state telehealth coverage mandates that had different colors, but there was no key available on that map as well?

[Deborah Baker] That would be mine…

[Jewel Edwards-Ashman] Oh, okay… yeah we had a bunch of questions about that map as well.

[Deborah Baker] Okay, thank you… so the orange states are the 35 states plus the District of Columbia that have enacted insurance coverage mandates for telehealth. So, in those states if you provide telehealth services… telehealth service, psychological services via telehealth, and those services are covered if they're provided in person, the insurance companies in that state have to cover them if they're provided by telehealth. They can't deny them simply because you use ten… excuse me… telehealth to provide them. The blue states are the states that have not enacted such a law and Louisiana limits on the insurance coverage only to physician services, so Louis… Louisiana may as well be blue for psychologist purposes. And then Illinois and Massachusetts, it's not mandatory coverage; it's discretionary. However, the state law says the insurance company can't put conditions therefore on the… on the coverage, so if they choose to recover telehealth services, they can't put additional conditions on it that they wouldn't put on comparable in-person services. North Dakota just amended its law, so now it's a full coverage mandate. It previously was limited; it was time-limited as kind of part of a demonstration project, but now it is a full coverage mandate.

[Jewel Edwards-Ashman] Okay, great -- we also have another question here: how does interstate telepsychology affect trainees under supervision? Trainees are not licensed, but they are supervised.

[Deborah Baker] Often… in some states it's… it's discussed in the Practice Act. I'm thinking to Montana, for example, where they talk about telesupervision, whether it's allowed, but typically it's still within the parameters of that particular state. It doesn't speak to interstate supervision and I'll flip it to Alex.

[Alex Siegel] I would just echo what Deborah just said. For example, New Mexico – their law talks about how you have to start off with supervision; it has to be face-to-face and then you can go to telepsych supervision once a person is competent to provide those services and how often you need to meet, but typically most states don't look at interjurisdictional supervision because if you are applying for licensure in one jurisdiction and you're doing all your supervision in that jurisdiction, there's no need to provide interjurisdictional supervision. So, a lot of… a lot of states really have not considered interjurisdictional supervision as part of their Practice Act, but I would again send you to either… actually you can go to the ASPPB website and there's a link to all of the state laws and rules and you can go to our website and go to that link and kind of read what the actual law and regulations are for licensure and so forth.

[Jewel Edwards-Ashman] Okay, and I think we have time for one or two more questions. Someone asked about Puerto Rico and I didn't… I don't see Puerto Rico on the map. If you're a psychologist in Puerto Rico, can you still provide telehealth services to clients who live in the States or is there… are there other restrictions?

[Alex Siegel] So the United States ASPPB is made up of the 50 states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. If Puerto Rico were to sign on… on the compact, then you could provide services from Puerto Rico into the 50 other states, but you need to make sure that you… your credentials in Puerto Rico would be recognized in the United States. So, for example, a lot of the psychologists that are licensed in Puerto Rico never took the E Triple P and therefore they would not be eligible for licensure or eligible under the compact to provides services into the mainland United States, but if they took the E Triple P, graduated from a program, met the other criteria, then they could, if… assuming that Puerto Rico adopts the compact, provide those services under the auspices of the compact.

[Jewel Edwards-Ashman] Thanks, and one more question: are there different telehealth guidelines for testing and for therapies? Are there separate guidelines for psychotherapy testing?

[Deborah Baker] The APA guidelines talk a bit about testing and assessment and I'm going to defer to Alex on this, but often you're going to have to understand the instrument itself versus wholesale testing through technology.

[Alex Siegel] And it also depends on the testing instrument that you're doing. If you're trying to do one of the Wexlers and you can do block designs, for example, you can't do that over the Internet. So maybe you have an associate that's sitting there with the patient to help facilitate the process. You also have to look at the norman… normalization and the validity of the reliability. How is that differently affected from a face-to-face session in the same room to over the Internet? And from what I've been told, some of these test companies are now beginning to do those validation studies to come up with some norms about using the testing when you're not in the same room. So the guidelines do talk about guidelines. There's one specific guideline on psychological testing that's another part of that and there's another part of that has to do with psychotherapy and it's also just like the APA ethics code. It's talked a little bit about in the informed consent process, in the data, and in the competency section as well as other sections throughout the APA guidelines.

[Jewel Edwards-Ashman] Okay, great -- thank you so much for answering those questions and we got a lot. So, we do plan to address… continue to address the questions that were sent in during the webinar and that you all are continuing to send us and once again if you have any other questions once this presentation ends you can email them to practice at APA dot org. Once again, this webinar is brought to you by the Practice Organization and to answer a last question that came in, yes, there will be a recording sent out to everyone who registered for the webinar. Thank you all so much for joining us and have a great afternoon.

[Alex Siegel] Thank you very much.