C·B·H

a division of DBHIDS

PROVIDER MANUAL SUPPLEMENT

Telehealth Best Practice Guidelines

Updated November 1, 2024

Community Behavioral Health

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1. USE OF TELEHEALTH BEST PRACTICE GUIDELINES

The utilization of telehealth has significantly increased over the past five years in the delivery of behavioral health services. Best Practice Guidelines ensure that all members receive high-quality, accountable, whole-person care, whether delivered in-person or via telehealth. By providing a range of telehealth solutions, we aim to enhance accessibility and convenience, allowing member choice to remain our top priority. Telehealth offers many benefits, including increased access to specialty providers, reduced costs for members and providers, improved staffing levels in a competitive environment, and more regular follow-up with enhanced continuity of care. Providers are strongly encouraged to offer both in-person and telehealth services whenever clinically feasible.

Community Behavioral Health (CBH) will use this document to clarify remote care standards and expectations for our providers and members. Key areas to address include the use of technology, preservation of confidentiality, member rights, remote individual and group therapy, medication management (including prescribing of controlled substances), delivery of Intensive Behavioral Health Services (IBHS), treatment of emergencies, documentation of services rendered, quality management, and addressing complaints and grievances.

2. DESCRIPTION

CBH defines telehealth, also known as remote or virtual treatment, as any service provided using technology when the member and provider staff are not in the same physical space during service delivery. This interaction must occur in real time. It should be noted that while the member must be present in most instances at inpatient or residential service locations, provider staff may be remote. Depending on relevant and current local, state, or federal requirements, the service may be provided using audio-only or audiovisual services.

Telehealth does not include store-and-forward methods, which involve collecting medical information to be sent to a specialist or professional for review, text messaging, email, routine appointment reminders, or other asynchronous technology.

Qualified or licensed provider staff are permitted to deliver care via telehealth if it is deemed the best and most appropriate manner to treat a member at a given time. Telehealth

services must adhere to the same regulations as in-person services and are subject to the same payment conditions.

The umbrella term *telehealth* may include the following:

- Care delivered by a practitioner on-site at a provider location while the member is at home, communicating via audiovisual teleconferencing
- Care received by a member at a provider site, delivered by a practitioner who is off-site and communicating via audiovisual teleconferencing
- Individual, group, case management, substance use, or medication management services delivered remotely through audiovisual teleconferencing
- Assessments (including those for emergency services) completed using audiovisual teleconferencing
- Audio-only (telephonic) communication as a substitute for in-person care; this is generally discouraged unless no other option is available due to unique or challenging circumstances

3. REQUIREMENTS

Providers must ensure that the technology used to complete telehealth services:

- Is Health Insurance Portability and Accountability Act (HIPAA) compliant,
- includes secure notes from unauthorized or untracked changes,
- can provide access to auditors and reviewers to notes in their original form, and
- can provide access to other treatment team members for effective care coordination.

Members must provide informed consent to receive telehealth services at the initiation of a new service. The Office of Mental Health and Substance Abuse Services (OMHSAS) states that providers must be able to provide in-person services at the member's request, including having access to an appropriate and licensed space within 45 miles or 60 minutes of the member being served. CBH providers cannot consist of telehealth-only services

without the ability to serve members in person. Additionally, CBH members may revoke consent for telehealth services at any point during treatment.

Progress notes must indicate that the service was delivered via telehealth and specify the platform used. Each telehealth service must include the appropriate place of service (POS) code on the corresponding claim. Failure to match the POS code with the note's content or to document the delivery via telehealth will be subject to overpayment recovery by CBH Program Integrity upon review. See below for the billing rules regarding the use of POS for telehealth.

When audio-only telehealth is utilized, the note must clearly explain the rationale for the choice of audio-only. Audio-only sessions should be used infrequently and reserved for instances where temporary challenges prevent using real-time audiovisual platforms.

Providers must adhere to applicable state and federal guidelines for services requiring a signed encounter form during service delivery. **OMHSAS Bulletin 22-02** allows providers to collect handwritten or electronic signatures. Providers must ensure compliance with relevant state and federal requirements when using electronic signatures during service delivery. Providers should refer to **ACT 69, section 103 of the 1999 Electronic Transactions Act** for information on valid electronic signatures. Claims for services that do not have appropriately completed encounter forms are subject to recoupment by CBH Program Integrity.

Providers routinely using telehealth services are strongly encouraged to use electronic medical records (EMRs) to allow real-time access to other treatment team members.

3.1. Telehealth POS Billing Reminders

When billing for telehealth, there are two decision points for billing:

1. Was telehealth provided as audio or video?
2. Was the member participating from home or another location?

For service dates 9/1/22 forward:

1. Audio-only telehealth services are billed using the FQ information modifier.
2. Audiovisual telehealth services are billed using the regular billing sentence, and the FQ modifier is NOT needed.

3. If the member participates in POS Home, claims will be submitted using POS 10.
4. If the member participates in telehealth from anywhere other than POS Home, claims must be submitted with POS 02.

4. DOCUMENTATION

Each service billed to CBH must be documented in the individual's clinical record. This documentation records interventions, progress, and challenges encountered during treatment. It allows provider staff, individual(s) in treatment, and subsequent providers to review effective treatment strategies and interventions.

Additionally, clear and concise clinical documentation is crucial for substantiating payments made to the provider. Clinical documentation must fully substantiate the service and its duration or amount billed for any billed service. All progress notes must document behavioral health interventions, clearly and concisely describing the member's and provider staff's contribution to the billed service.

An individual unfamiliar with the member's course of treatment should be able to discern what has been effective and ineffective and what is in process in the member's care through record review alone.

When documenting interventions, the writer must provide an accurate and complete service description. Clinical documentation should avoid vague, general language and buzzwords for theoretical models.

See the table below for examples of statements that do not sufficiently summarize the intervention delivered.

Problematic Statements	Specific Concerns
"Listened and provided positive feedback"	This is a basic tenet of all behavioral health care.
"Used Cognitive-Behavioral Therapy"	This statement of a broad evidence-based theoretical framework contains several specific clinical interventions that can be utilized.
"Role-played with the individual"	Alone, there is no specific information about what scenarios were role-played, how it tied to the treatment plan, and the outcome of the role-playing.
"Provided a warm and safe environment for exploration of the individual's concerns"	This is a basic tenet of all recovery-based behavioral health care.

Problematic Statements	Specific Concerns
"Watched a video on the effects of substance abuse"	Watching videos does not alone constitute an intervention. Discussions of relevant audio-visual presentations can sometimes include behavioral health interventions.

Progress notes must indicate that the service was delivered via telehealth and specify the service delivery platform. All providers should develop and maintain a policy and procedure for progress notes, including the required elements to substantiate a service rendered. The policy should include a discussion or review of the following:

- The provider's quality assurance process for review of progress notes to ensure sufficiency
- At a minimum, the policy should address:
  - Documentation of interventions utilized/implemented and the member's response to those interventions
  - Documentation of an assessment of the individual's behavior, mood, and interpersonal functioning
  - Documentation of review(s) of relevant medical conditions and lab work
  - Individualized response to group sessions
- A listing of who is authorized to document interventions/interactions in the clinical record
- Any formal progress note formats adopted by the agency
- Expectations of content to be included in the adopted progress note format
- Expectations and review processes to ensure that progress notes reflect treatment plan goals
- Expectations that the note will be entered and considered final before the submission of a claim for that date of service or within seven days of the date of service, whichever occurs first

- Expectations that corrections to note entries will be completed consistent with overall agency policy and applicable regulations
- Assurance and process for auditors/reviewers to access notes in their original form

5. MEMBER RIGHTS

Members' preferences and needs guide all decisions regarding telehealth service delivery. The following areas outline best practices and requirements related to member rights specific to telehealth.

- Informed consent must include identification of all persons present at each end of the telehealth transmission and the role of each person.
- A member can refuse services delivered through telehealth, and providers cannot use such refusal as a basis to limit the member's access to in-person services.
- The member must be informed and fully aware of the role of provider staff and others responsible for follow-up or ongoing care.
- The member's needs, including the severity of the condition, must be carefully considered in determining the appropriateness of receiving telehealth services.
- The clinician should always consider a request for telehealth, but it is up to the clinician's professional judgment to determine whether this serves the member's best interests.
- Under Title VI of the Civil Rights Act and as outlined in the CBH Provider Agreement, providers who receive federal funds are responsible for ensuring the availability of language and communications services to individuals with limited English proficiency individuals and should have an internal language access plan to do so for all services.

For a comprehensive overview of Member Rights, please visit **cbhphilly.org**.

6. EXPECTATIONS OF SERVICE DELIVERY

The decision to use telehealth should be based on clinical appropriateness and member preference. Even if telehealth is clinically appropriate, if the member requests in-person services, that request should be accommodated. Telehealth should never be utilized because of the preference or convenience of the provider or behavioral health practitioner. Before initiating telehealth, and on an ongoing basis, the provider must clinically assess whether telehealth is appropriate for each member and situation. The appropriateness of telehealth services may vary throughout treatment, and practitioners must discuss the possibility of service delivery changes with the member.

Member and family choices should be prioritized when determining the appropriateness of telehealth delivery. However, no service should be provided through telehealth if, in the best clinical judgment of the licensed practitioner, it is not clinically appropriate or could result in a lower quality of care or delayed treatment.

6.1. Determining Appropriateness for Telehealth

Providers must have policies that indicate the factors considered when determining if telehealth is clinically appropriate for a member. These policies should detail how the determination or recommendation is communicated to the member and how the recommendation and member response are documented in the medical record. Providers should also document clinical indications to revisit the appropriateness of telehealth and ensure these have been shared with the member.

Factors to consider include, but are not limited to:

- Preference of the member and their family
- Age of a minor child and ability to consent for and effectively participate in telehealth services
- Clinical needs for in-person assessments and interventions
- Level of symptom acuity
- Risk of harm to self or others and ability for practitioner to regularly assess safety via telehealth

- Ability of the member served to communicate, either independently or with accommodation such as an interpreter or electronic communication device
- Ability for interventions to be delivered effectively via telehealth
- Member's access to technology
- Whether privacy for the member served can be maintained if services are delivered using telehealth
- Any unresolvable barriers to in-person service delivery for the member

When the use of telehealth is not clinically appropriate, the licensed practitioner or provider agency must offer in-person services and ensure the member is linked to proper in-person services.

While telehealth can be a valuable tool, it is best suited for outpatient interventions. Therefore, CBH expects the following services to be delivered primarily in-person:

- Inpatient/Partial
- Mental Health (MH) and Substance Use Disorder (SUD) Residential
- Intensive Outpatient Programming
- Intensive Behavioral Health Services (IBHS)
- Family-Based Mental Health
- Assertive Community Treatment (ACT)
- Children's Mobile Intervention Services (CMIS)
- Community Intervention Stabilization Team (CIST)

Telehealth may augment in-person service delivery during the treatment episode to support and enhance connections to collateral contacts and supports. However, it should never be the primary service delivery mechanism. Telehealth may also be used as a backup delivery method on rare occasions when illness or other safety concerns prevent in-person service delivery. For community-based services, telehealth can support members in crisis while in-person intervention is being dispatched, but it should not be used in lieu of in-person dispatch.

6.2. Emergencies

An emergency may arise during a telehealth session from various causes, including a mental health crisis, physical health issue, or overdose. In advance of telehealth interactions, providers should create an emergency plan with members, based upon recommendations from **hhs.gov**, to address the following questions:

- What is your current location?
  - Confirm the individual's location at the beginning of each appointment and get their full address.
- Do you understand 911 and 988 and how they might be used?
- Who is your local emergency contact or support person? A family member, friend, or neighbor nearby who can offer help in a crisis?
  - Secure the individual's authorization to release information to emergency contact if needed.
- What happens if the call is disconnected during an emergency? Who will call whom, and at what number?
  - Plan for alternate ways to reconnect with your patient via phone or an alternate video platform.
- What situations will lead to putting the crisis plan into action?
  - Crisis Plans are based on specific needs and are designed to support the individual's safety and stability. If the individual reports engaging in unsafe behaviors and experiencing thoughts of harming self or others, the provider will assist the individual in accessing safety support as needed.
- What will happen in the event of an emergency? For example, when should an emergency contact be called to help check on the individual or call 911/988 from their location?
- What happens if you miss an appointment and a crisis is suspected?
  - It is helpful, especially for individuals who have not received mental health services before, to expect a call from the provider's office if an

appointment is missed and that a return call/text message is appreciated. Hence, the provider knows the person is safe. Explain to the person receiving services that a provider has a duty of care that may require them to request police do an emergency safety check if a crisis is suspected.

- What circumstances will require a referral for immediate in-person evaluation or treatment?
  - Suppose the individual reports engaging in unsafe behaviors or experiencing thoughts of harming self or others. In that case, the provider will shift the session's focus to a collaborative assessment of the individual's immediate safety needs.
  - The provider may recommend an in-person session to allow for a more thorough assessment of safety needs and determine what treatment is needed to keep the individual safe.
  - If individuals cannot consistently keep telehealth appointments, they may be advised to switch to in-person treatment.

6.3. Medication Management

When conducting telehealth sessions focused on medication management, following the same procedures employed during in-person treatment is essential. This includes gathering a complete medical and medication history, including allergies and past reactions to medications (both positive and negative), and documenting the current medication regimen while assessing any need for treatment adjustments.

While specific examinations, such as the Abnormal Involuntary Movement Scale (AIMS), are very challenging to conduct accurately in a telehealth session, providers must still closely monitor potential side effects according to standards of care. Telehealth providers must also meet standards of care for laboratory monitoring of possible medication side effects, such as annual metabolic monitoring of patients taking antipsychotic medication.

Each medication should be discussed comprehensively, covering potential side effects, risks, and benefits, alongside clear guidance on dosing and treatment duration. Members must be provided with a reliable means to contact telehealth providers in case of adverse events rapidly. Electronic prescribing of medications is preferred for accuracy, safety, and consistency.

6.4. Prescribing of Controlled Substances via Telehealth

The Drug Enforcement Administration (DEA) has issued the following information regarding the prescribing of controlled substances via telehealth:

> *Under the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (the Ryan Haight Act), a prescribing practitioner—subject to certain exceptions—may prescribe controlled medications to a patient only after conducting an in-person evaluation of that patient. In response to the COVID-19 Public Health Emergency (COVID-19 PHE), as declared by the Secretary (the Secretary) of the Department of Health and Human Services (HHS) on January 31, 2020, pursuant to the authority under section 319 of the Public Health Service Act (**42 U.S.C. 247**), the Drug Enforcement Administration (DEA) granted temporary exceptions to the Ryan Haight Act and DEA's implementing regulations under **21 U.S.C. 802(54)(D)**.*
>
> *In order to prevent lapses in care, these exceptions allowed for the prescribing of controlled medications via telemedicine encounters even when the prescribing practitioner had not conducted an in-person medical evaluation of the patient. These telemedicine flexibilities authorized practitioners to prescribe schedule II-V controlled medications via audio-video telemedicine encounters, including schedule III-V narcotic controlled medications approved by the Food and Drug Administration (FDA) for maintenance and withdrawal management treatment of opioid use disorder via audio-only telemedicine encounters, provided that such prescriptions otherwise comply with the requirements outlined in DEA guidance documents, DEA regulations, and applicable Federal and State law. The Controlled Substances Act (CSA) generally requires practitioners prescribing controlled substances to patients in another state via telemedicine to be registered in those patients' state.*
>
> *The DEA, jointly with the Department of Health and Human Services (HHS), extended current telemedicine flexibilities (initiated during the recent COVID Public Health Emergency) through December 31, 2024.*

Under the current DEA guidance, prescribing controlled substances via telehealth-only appointments is deemed acceptable provided that:

- The prescription is issued for a legitimate medical purpose by a licensed practitioner acting in the usual course of their professional practice

- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system
- The practitioner is acting by applicable federal and state laws

6.5. Diagnostic Testing, Evaluations, Assessments

There are several unique considerations to patient safety and emergency management when practicing telehealth, as noted in the American Psychiatry Association (APA) Telepsychiatry Toolkit:

- When evaluating member safety, make every attempt to assess the level of agitation, the potential for harm to self or others, and any safety hazards (such as firearms) that might be accessible.
- If applicable, the provider should become familiar with the facility/venue where the individual is located, including immediate professional staff who may be available in a clinical crisis. The provider should also be aware of institutional emergency procedures and ways to obtain collateral information.
- Being mindful of these issues during a telehealth session will help the provider determine the need for higher levels of acute care, such as involuntary hospitalization, changes in levels of observation, or possibly changes to the medication regimen.
- Technology may be effectively employed during the session to allow for careful inspection of the individual for verbal and visual cues of agitation, aggression, worsening depression, mood, anxiety, or other possible factors related to imminent safety.

6.6. Individual Therapy

The appropriateness of telehealth services may vary for members throughout treatment, requiring practitioners to regularly review the potential changes in service delivery with the member. Providers must carefully examine the unique benefits of telehealth services, such as access to care, access to consulting services, client convenience, and accommodation of special needs, against the unique risks, such as information security and emergency management, when determining whether to offer telehealth services.

Providers must carefully assess the remote environment to ensure member privacy and safety and to determine the effectiveness of delivering interventions via telehealth.

Providers are responsible for monitoring and regularly assessing the member's progress to determine if the provision of telehealth services remains appropriate. If the provider determines that telehealth is no longer clinically relevant due to changes in the member's presentation or recommended interventions, they must review this with the member. The licensed practitioner or provider agency must then offer the services in person or, based on member choice, ensure the member is connected to appropriate in-person services at another location.

6.7. Group Therapy

Key considerations for providers conducting group therapy via telehealth include:

- Consider the benefits versus risks of offering group sessions via telehealth.
- Members must be informed of the risks, benefits, and limits to confidentiality before consenting to group treatment.
- Educate members who consent on the group roles, responsibilities, and guidelines.
- Establish policies and procedures to address privacy protection, confidentiality breaches, safety concerns, and connectivity or technology issues.
- How will the group address process issues?
- Plan to ensure the safety of all group members.
- Inform members of the risks, limitations, and benefits of participating in group therapy via telehealth.

The APA emphasizes several risks to confidentiality that must be included in the informed consent process. Group leaders should have clients read and sign informed consent forms for group telehealth before the first session, ensuring they are aware of the risks, benefits, and limits to confidentiality. It is the group leader's responsibility to adhere to and uphold the highest privacy standards for the group.

While the group leader must maintain confidentiality, in most states, group members are not bound by the same legal or ethical imperative. Although video platforms can be

beneficial, they pose more significant risks to the client's confidentiality than in-person groups.

Potential breaches of confidentiality may include, but are not limited to:

- A group member attending a group in a non-secure location where a nonmember (e.g., a family member or roommate) can see or hear the group
- A member recording or taking screenshots of group members

6.8. Intensive Behavioral Health Services (IBHS)

IBHS services support children, youth, and young adults with mental, emotional, and behavioral health needs. These services are offered across various service types, including individual therapy, Applied Behavior Analysis (ABA), group therapy, and evidence-based therapy. They can be provided in the member's home, school, and community.

CBH expects IBHS services to be delivered primarily in person due to the intensive nature of the service. Telehealth may supplement in-person service delivery during the treatment episode to support connections to collateral contacts and supports, but it should never serve as the primary service delivery method. In rare cases, telehealth may serve as a backup delivery method to provide access to care when illness or other safety concerns prevent in-person service delivery. For community-based services, telehealth can support members in crisis while a clinician is en route to a member's location, but it should not be used instead of in-person dispatch.

7. PROVIDER POLICIES

Providers utilizing telehealth must establish and maintain a policy that includes, but is not limited to, procedures for the following:

- Obtaining informed consent before providing telehealth services
- Scheduling appointments and accessing the telehealth platform, including contingency plans for technical challenges
- Assessing each member to determine the appropriateness of telehealth based on the member's treatment needs
- Addressing danger to self or others as mandated and required by law

- Handling emergencies and crises, including how resources will be accessed
- Supporting members with limited English proficiency or disabilities such as hearing loss or visual impairment
- Adequate documentation and record-keeping
- Ensuring privacy and security measures in compliance with HIPAA
- Monitoring the sustainability and success of telehealth services

8. QUALITY MANAGEMENT

8.1. Outcomes

Providers are advised to track show/no-show rates for telehealth and in-person services to facilitate comparisons. This data should be readily accessible for reporting to CBH upon request. Additionally, providers should incorporate telehealth-related questions into client satisfaction surveys and discharge planning tools. By using this data, providers can enhance the delivery of telehealth services and incorporate Plan, Do, Study, and Act cycles as needed.

CBH will also conduct an annual analysis to compare the percentage of follow-up appointments within 120 days from the first to the second service for telehealth and non-telehealth services.

Key Performance Indicators (KPIs) are specific performance measurements used to monitor, analyze, and optimize all relevant processes to increase member satisfaction and safety. These indicators are reviewed quarterly and vary based on the level of care. Examples of KPIs include medication errors, mortality rates, and overturned complaints.

An outlier is defined as one standard deviation above the mean compared to providers within the same level of care. If a provider is identified as an outlier, they are typically asked to conduct a Root Cause Analysis (RCA) to determine any contributing factors and develop a plan to address them.

8.2. Complaints

CBH provides a structured process for all members to file a complaint related to care or services, per the HealthChoices Program Standards and Requirements Appendix H.

Managed by CBH's Quality Management Department, this complaint process involves collaboration with the provider to investigate the member's complaint.

The identified provider will receive an acknowledgment letter summarizing the complaint. Once a complaint is acknowledged, CBH's Quality Management Department will contact the provider within five business days to schedule an interview or site visit to discuss the information needed to investigate the complaint.

The investigation information is presented to a first-level complaint review panel, which issues the first-level complaint decision. CBH must make a decision and send a letter to the member explaining the findings and the reasons for the decision within 30 calendar days of receiving the complaint. If requested by the member, CBH may grant a 14-day extension.

Throughout the process, any identified quality concerns made by the investigator or panel may result in corrective action. In addition to the first-level complaint review, a member can request a second-level complaint review. Like the first-level complaint investigation process, CBH expects providers to participate if a member requests their involvement in the second-level complaint investigation. Providers receive copies of complaint decision letters.

Additionally, providers should establish internal written policies and procedures for handling member complaints. This process should be documented in a member's medical record. A member receiving services should be provided with information explaining the agency's complaint and grievance policies.

8.3. Quality Care Concerns

Quality care concerns are concerns raised during other operations. These may include findings from Network Improvement and Accountability Collaborative (NIAC) audits that exceed the scope of the performance improvement plan process, concerns discovered by Clinical Management or Medical Affairs as a result of care management and other related activities, or concerns discovered by Member Services regarding incidents and member concerns when members do not wish to file a formal complaint.

Quality care concerns are entered for assessments, care coordination, discharge planning, treatment, prescribing practices, and other related matters. CBH's Quality Management Department analyzes trends in this data across providers within the same

level of care. Based on this data, corrective actions may be required to address identified areas for improvement.

APPENDIX

The American Psychiatric Association (APA) provides some **Best Practice Guidelines** for telehealth for both providers and members:

- A solid video and room setup is key to a successful telehealth encounter. Many providers are seeing new members for the first time over video whom they've never met in person, so getting the technology right for the first encounter is especially important.
- Keep doors and windows closed, introduce anyone else in the room, and ensure they remain in the line of sight. To protect members' privacy in your treatment setting, strongly consider using a headset.
- Keep the room well-lit, and ensure your webcam is placed above the computer screen, not below or to the side.
- For new members, ensure they know how to use the technology and offer assistance in setting up their space when possible.
- Consider offering a brief survey to members new to telehealth to gauge their comfort level with technology and assess the type of technology they will use for the encounter. You might also consider scheduling a brief pre-visit intake session to address any concerns they may have about using the technology so that these don't interfere with the first clinical visit.
- Establish a protocol to be followed in an emergency and communicate this explicitly with the member. Assess the member's location and document who you should contact should an emergent situation arise. Also, a backup plan should be in place for technical issues, such as losing an internet connection. It is recommended that this protocol be included in agency policy and procedures. See the "Provider Policies" section below for further information.
- If the video link goes down, maintain a second mode of communication with the member (e.g., a second video link or telephone).

- At the beginning of each telehealth session, establish the member's location and identify any natural supports available to assist in an emergency.

Definitions

In-Person

Services provided where both participants are in the same physical location

Face-to-Face

Services provided where the participants can be in-person or meeting virtually via videoconference.

Please Note: *Audio-only (telephonic) services do not count as in-person or face-to-face.*

References

1. **OMHSAS Behavioral Health Telehealth Information**
   Office of Mental Health and Substance Abuse Services (OMHSAS)
2. **OMHSAS-22-02: Revised Guidelines for the Delivery of Behavioral Health Services Through Telehealth**
   Office of Mental Health and Substance Abuse Services (OMHSAS)
3. **ACT 69 of the 1999 Electronic Transactions Act, Section 103**
   Pennsylvania General Assembly
4. **Proposed Rule: Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation**
   Drug Enforcement Administration (DEA), Department of Justice
5. **Telepsychiatry Toolkit**
   American Psychiatric Association, Patient Safety and Emergency Management