



# Practical and Regulatory Considerations of Teleprescribing via CVT

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## Abstract

**Purpose of Review** Clinical video teleconferencing (CVT) represents a robust mechanism for more accessible medical care. Providers who practice medicine via CVT, including teleprescribing, should understand a number of core practical and regulatory factors. This paper aims to review these core factors, such that providers new to CVT may offer teleprescribing services in a manner consistent with current clinical standards and regulatory requirements.

**Recent Findings** A number of practical factors relate to the setup and delivery of teleprescribing services that are contextually influenced by federal and state law.

**Summary** This review will elucidate the practical and regulatory factors relevant to teleprescribing and encourage the use of CVT for patient care. Through consideration of these factors, providers may better implement teleprescribing and prepare for future technology and policy changes relevant to practice.

**Keywords** Clinical video teleconferencing · CVT · Telemedicine · Teleprescribing · Regulations

## Introduction

The geographic distribution of medical providers in the U.S. has made accessing in-person medical care problematic and even impossible for many Americans [1]. Videoconferencing technology has become a powerful tool for accessing health care when barriers to in-person services exist. The use of video conferencing as a general means of communication will soon be ubiquitous, with current video conferencing utilization in the U.S. estimated at 88% for those 18–34 years old, 68% for those 35–54, and 35% for those 55 and older [2]. Furthermore, providing clinical care via video conferencing technology, referred to as clinical video teleconferencing (CVT), has

become established as an evidence-based modality for the provision of medical services [e.g., 3].

While there is great potential for CVT to make medical care more accessible, a number of practical and regulatory factors must be considered to prescribe medication via this modality legally and with the same standard of care as an in-person visit. This review intends to guide providers interested in offering teleprescribing services, including the prescribing of controlled and non-controlled medications. We first describe the core components of CVT-based teleprescribing, then introduce the practical and regulatory considerations that confront providers who teleprescribe. When approached with a tactical framework, CVT-based teleprescribing becomes a systematic practice that can be at once professionally rewarding and profoundly beneficial to patients.

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## Core Components

CVT does not fundamentally change the way one provides care if engaged in routine prescribing services. One should observe that the quality of care delivered through CVT has generally been shown to be comparable to care delivered in person [3]. However, this evaluation presupposes the practical and administrative foundation that must be in place before the CVT encounter. To achieve a similar scope of practice as that

provided in person, one should think through the core components and routine systems of care in place during traditional in-person practice and ensure that the same elements are in place before delivery of care via CVT. Professional guidelines and published best practices, such as the joint report published by the American Psychiatric Association and American Telemedicine Association (APA-ATA), can assist [4]. For example, the APA-ATA recommends completing a needs assessment as a starting point to ensure that general systems are reviewed and a plan exists to implement or adapt what is in place for compatibility with CVT.

Core components are most basic when CVT is provided to a clinic registered with the Drug Enforcement Administration (DEA) and within the same health care system and state. As the patient's location changes, such as to a non-DEA-registered clinic, a non-clinic location (e.g., private residence, work), other health care system, or out-of-state location, considerations for practitioners increase in complexity. Table 1 summarizes these core components and how they vary based on patient location type during a telehealth encounter, while Table 2 summarizes possible regulatory requirements providers will encounter by jurisdictional scope (i.e., intrastate, interstate).

### 1. Technology

Numerous options exist for video conferencing; however, not all are appropriate for health care. When providing teleprescribing services to another clinic, all locations involved must have HIPAA-compliant hardware and software, which may vary based on a patient's presence in a clinic or non-clinic location. When a patient is at a clinic for a CVT encounter, consider a dedicated telehealth cart in front of which a patient can be seated, as opposed to a computer with a webcam. Telehealth carts are relatively secure units designed to facilitate a CVT connection, whereas a computer with webcam often requires secure log-ins and may provide patient access to protected information. When CVT is provided to a non-clinic location, less formal telehealth configurations, such as a computer with a webcam or mobile device, are often appropriate. While different hardware systems may require different software, CVT setups can generally interact with one another. For example, providers may use a telehealth cart in their office to call a telehealth cart at another clinic location, or call a patient's computer at a non-clinic location, wherein the interacting devices may use different software. It should be noted that HIPAA-compliant telehealth is not merely achieved through software and hardware. Suitable telehealth technology must also be used in a HIPAA-compliant manner. Additionally, telehealth locations must ensure sufficient bandwidth for a smooth connection. Some regions in the U.S. struggle with Internet connectivity issues, which in some cases may be anticipated using analytic services found on the web [5]. In addition, some organizational

networks may lack capacity to support the numerous, concurrent CVT connections that may occur at a clinic.

### 2. Credentialing and Privileging / Reimbursement

Providers should verify with their facility whether specific privileges are required to provide teleprescribing services. If working with third-party payers, providers should check with each insurer to determine: (a) whether privileges are required, (b) whether the insurer reimburses for teleprescribing services, (c) what teleprescribing services are reimbursed, and (d) at what rate services are reimbursed. Reimbursement policy undergoes constant change, and policies may differ between insurers and across different areas in the country. For example, some plans may not reimburse for CVT delivered to non-clinic locations, while others may reimburse for CVT services at a lower rate. If providers seek reimbursement through Medicare or Medicaid, they should understand how relevant rules and regulations apply by region and by type of CVT services offered.

### 3. Malpractice Insurance

If providers carry malpractice insurance, they should check their policy to ensure it covers teleprescribing services. Some plans may cover certain telehealth configurations and not others, or not cover telehealth whatsoever.

### 4. Logistics and Support

Providers should be cognizant of logistics and support considerations. Providers should consider who, if anyone, will provide technical support during a CVT encounter, as technical problems can arise. If delivering telehealth between multiple health care systems, providers will require access to the electronic health record (EHR) for each site, and the ability to order labs and take vital signs, as needed. Providers should also conform to the practice standards specific to a patient's health care system (e.g., antipsychotic use monitoring) and hold privileges at a pharmacy that can support the patient. Prior to telehealth delivery to a clinic location, providers should ensure patient access to a private and reserved space to meet via CVT. Additionally, staff must be present at the clinic to seat the patient and assist during an encounter. Ideally, this role is filled by a nurse who can assist with labs and vital signs, as needed. Prior to telehealth delivery to a non-clinic location, it may be helpful to have staff conduct a test call with a patient to ensure any upcoming appointment proceeds without incident. When providing telehealth to a non-clinic location, it is of paramount importance for providers to consider the privacy of a patient's location and consider how a patient may obtain ancillary services such as labs and vital signs. Telehealth peripherals may be useful in this regard.

**Table 1** Core component considerations for teleprescribing segmented by patient location

Core Components	DEA-Registered Clinic	Non-DEA-Registered Clinic	Other Non-DEA-Registered Location
1. Technology	a. Ensure provider, clinic, and/or patient possess appropriate hardware and software to furnish telehealth. b. Ensure telehealth hardware and software are HIPAA compliant. c. Ensure adequate Internet bandwidth for smooth, uninterrupted connection.		
2. Credentialing & Privileging / Reimbursement	a. Verify credentialing and privileging to practice in all health care systems involved. b. Verify services offered are reimbursed if working with third-party payer.		
3. Malpractice Insurance	a. Verify malpractice insurance covers telehealth services offered.		
4. Logistics & Support	a. Consider who, if anyone, will facilitate technical support during encounter. b. Verify access to EHR associated with patient’s health care system. c. Identify space suitable for clinical care delivery. d. Adhere to health care system monitoring protocols for medications (e.g., antipsychotics). e. Confirm ability to order/review labs and be alerted to abnormal lab results. f. Establish means to obtain vital signs and alert prescriber of results. g. Verify ability to order medications and establish what medications patient may receive from other providers. h. Ensure access to pharmacy with approved privileges.		
	a. Reserve space at clinic to seat patient. b. Identify staff who will seat patient and join room as needed.	a. Consider who, if anyone, will conduct pre-encounter test call with patient. b. Consider use of telehealth peripheral for assessment of vital signs.	
5. Consultation	a. Ensure system to consult with colleagues for clinical discussion and seek support.		
6. Emergency Plan	a. Establish emergency plan that accounts for patient location and available resources. b. Review emergency plan with patient for accuracy. c. Establish provider and patient telephone numbers for backup contact.		
	a. Review emergency plan with clinic staff for accuracy. b. Maintain accurate clinic phone numbers. c. Ensure staff retains backup telephone number for contact. d. Ensure staff availability to enter room and provide support.	a. Consider identifying someone local to patient who could assist in an emergency. Obtain release of information, as needed.	
7. Documentation	a. Specify delivery via CVT, include informed consent for telehealth, and detail emergency plan. b. Follow relevant state telehealth documentation laws.		
8. Legal	a. Ensure appropriate licensure and registration with DEA for state in which patient is located (or comparable function in VA or IHS). b. Consider need for licensure in multiple states. c. Practice in accordance with laws of state in which patient is located. d. Adhere to laws of state(s) where licensed and/or located during encounter. e. Seek legal consultation as needed.		
		a. Adhere to Ryan Haight Act.	

5. Consultation

Telehealth is a robust tool for connecting people; however, it may isolate providers from interaction with other staff, such as a telehealth practice staffed across multiple states. The ability to seek consultation and receive support is critical. For remote practices, the same technology used for patient

telehealth encounters may also be used to foster a community of practice.

6. Emergency Plan

Providers should formulate a defined emergency plan when using CVT to meet with a patient. This plan should

**Table 2** Possible regulatory requirements for teleprescribing by jurisdictional scope

Jurisdictional Scope	Possible Regulatory Requirements
Intrastate <sup>a</sup>	<ul style="list-style-type: none"> <li>a. Medical board licensure in state of practice</li> <li>b. Controlled substances restriction               <ul style="list-style-type: none"> <li>i. III-IV</li> <li>ii. II-IV</li> </ul> </li> <li>c. Prescription format               <ul style="list-style-type: none"> <li>i. Electronic</li> <li>ii. Written</li> </ul> </li> <li>d. Prescription drug monitoring program (PDMP) verification</li> <li>e. Teleprescriber continuing medical education</li> </ul>
Interstate	<ul style="list-style-type: none"> <li>a. Medical board licensure, special purpose license, or telemedicine license/certificate               <ul style="list-style-type: none"> <li>i. Originating site state</li> <li>ii. Interstate Medical Licensure Compact (IMLC)</li> </ul> </li> <li>b. Active DEA-registration in originating site state</li> <li>c. Qualification for special circumstances under practice of telemedicine               <ul style="list-style-type: none"> <li>i. Possession of DEA-issued special registration</li> <li>ii. Medical emergency within the VA</li> <li>iii. Public health emergency declared by Secretary of HHS</li> <li>iv. Employment, contract, or compact with IHS</li> <li>v. Other circumstances determined jointly by DEA Administrator and Secretary of HHS</li> </ul> </li> </ul>
Department of Veterans Affairs	<ul style="list-style-type: none"> <li>a. Medical board licensure (in any state)</li> <li>b. DEA registration               <ul style="list-style-type: none"> <li>i. DEA registration with VA in any state</li> <li>ii. Ability to use DEA registration of VA clinic or hospital</li> </ul> </li> <li>c. Qualification for special circumstances under the practice of telemedicine               <ul style="list-style-type: none"> <li>i. Medical emergency within VA</li> <li>ii. Public health emergency declared by the Secretary of HHS</li> <li>iii. Other circumstances determined jointly by DEA Administrator and Secretary of HHS</li> </ul> </li> </ul>
Indian Health Service	<ul style="list-style-type: none"> <li>a. Medical board licensure               <ul style="list-style-type: none"> <li>i. Federal employee (federal requirements apply)</li> <li>ii. Tribal employee (requirements vary by licensing board)</li> </ul> </li> <li>b. Internet Eligible Controlled Substance Provider designation</li> <li>c. Qualification for special circumstances under the practice of telemedicine               <ul style="list-style-type: none"> <li>i. Public health emergency declared by the Secretary of HHS</li> <li>ii. Other circumstances determined jointly by DEA Administrator and Secretary of HHS</li> </ul> </li> </ul>

<sup>a</sup>Regulatory requirements at the intrastate level may extend to the interstate, Department of Veterans Affairs and Indian Health Service levels.

consider context-dependent resources, such as those at a patient's location at the time of an appointment (e.g., staff), as well as resources that exist in a patient's community (e.g., clinics, emergency departments). When CVT is provided to a clinic, both the patient and staff should retain a provider's telephone number, and providers should have means to communicate with clinic staff in the event on-site support is needed. Providers should also establish a telephone number to contact a patient in the event of dropped CVT connection or an emergency. A designee at the clinic should be trained to implement the same emergency response plan as would be

implemented at that location during an in-person emergency. When CVT is provided to a non-clinic location, providers may also wish to identify an individual near the patient who can assist in the event help is required; however, patient privacy must be weighed. Providers should also be aware of a patient's location during a telehealth encounter, such that they can contact emergency services with sufficient information to direct an emergency response. Notably, 911 calls in the U.S. are local to the area in which the call is placed, and private companies offer a database of 10-digit numbers that allow direct dial of emergency services. Finally, providers should review

the established emergency plan with both the clinic and the patient.

## 7. Documentation

Documentation practices for teleprescribing encounters parallel those for in-person care. Generally, providers should document the modality of encounter as CVT, the informed consent specific to CVT, and the emergency plan. States can differ with respect to required CVT documentation elements, and providers should verify these requirements for the place of care, principally defined as the state in which a patient is located [6].

## 8. Legal

Teleprescribers must comply with both federal and state regulations. States can differ with regard to telemedicine law. For example, a state may require that CVT-based care be accompanied by some level of in-person care, or require that informed consent for telemedicine be signed by a patient. The American Telemedicine Association (ATA) offers a comprehensive overview of each state's telemedicine requirements, complete with hyperlinks that direct readers to websites specific to these state laws [7•].

## Regulatory Considerations

Legal requirements for teleprescribing non-controlled substances are generally consistent with the requirements for in-person prescribing, so long as done in a manner consistent with relevant state law. However, teleprescribing controlled substances is also regulated on a federal level by the Ryan Haight Act [8•]. The Ryan Haight Act specifies that controlled substances can be teleprescribed only with a "valid prescription." Further, a practitioner must issue a valid prescription for a "legitimate medical purpose," "in the usual course of professional practice," and generally, only after at least one in-person medical evaluation of the patient, unless a covering practitioner is acting on behalf of a primary practitioner who has completed an in-person medical evaluation of the patient, or met with the patient via telemedicine within the past 24 months.

The Ryan Haight Act identifies specific telemedicine configurations that allow providers to teleprescribe controlled substances without meeting the in-person evaluation or covering practitioner requirements. Firstly, practitioners may teleprescribe controlled substances without a prior in-person exam if they are engaged in the "practice of telemedicine," whereby a patient is (a) physically located at a DEA-registered hospital or clinic or (b) in the physical presence of a DEA-registered practitioner [8•]. In both cases,

the practitioner delivering care must be DEA-registered in the same state as the patient's physical location, unless one of two exceptions apply: (a) the practitioner is exempted from DEA registration in all states or (b) the practitioner is DEA-registered with the Department of Veterans Affairs (VA) in any state or using the DEA registration of a VA hospital or clinic [9].

Secondly, practitioners who qualify for one of five special circumstances are both exempted from the in-person evaluation requirement, as well as the practice of telemedicine requirements described immediately above. These circumstances include: (a) possession of DEA-issued special registration; (b) patient medical emergency within the VA; (c) public health emergency declared by the Secretary of Health and Human Services (HHS); (d) employment, contract, or compact with the Indian Health Service (IHS); or (e) other circumstances the DEA Administrator and Secretary of HHS have jointly determined [8•]. However, providers may still be barred from teleprescribing controlled substances if state laws present more restrictive requirements, such as an in-person patient exam or outright prohibition of the practice. Notably, the special registration provision has not yet been activated, but Congress has established a deadline for the DEA to do so under the SUPPORT Act of 2018 [10•]. In general, providers should adhere to the most stringent combination of federal and state regulations possible, or otherwise, defer to the Ryan Haight Act if faced with conflicting or asymmetric requirements [11•].

**Intrastate Practice** Providers who seek to practice within a single state should verify the licensure requirements for the practice of telemedicine in that specific state. They should also verify which schedules of controlled substances may be legally prescribed in that state. States may also require that teleprescribers possess a controlled substances registration, and additionally, furnish a written prescription, review a prescription drug monitoring program database, and satisfy specified continuing medical education requirements [11•].

**Interstate Practice** Providers must have legal authority to practice in the state where a patient is located during a CVT encounter and follow the laws of that same state [6]. This has significant implications for interstate practice. Some states require that providers obtain a full license to teleprescribe to that location, while other states may grant special permission to practice via telemedicine on a limited basis. In addition, the Interstate Medical Licensure Compact (IMLC) can facilitate providers engaged in multi-state CVT through reciprocal licensure/telemedicine certification requirements among member states [12]. Providers should also note that interstate practice has potential to create legal liability across multiple states (i.e., a patient's physical location, a provider's physical

location, and location(s) of a provider's licensure). Providers may not only need to be licensed in the state in which a patient is located, but also in the state from which they are practicing, if different. Providers are encouraged to verify with their state medical board whether licensure within their state is required to practice telemedicine *from* there, even if not practicing *to* there. In every case, interstate practitioners should proceed carefully and understand differences in state-to-state regulations, communicate with relevant licensing boards, and seek legal consult, if necessary.

**Veterans Affairs Practice** Providers within the VA or IHS systems may benefit from more streamlined teleprescribing regulations. The Authority of Health Care Providers to Practice Telehealth Act [13] allows a VA doctor, nurse, or other health care provider to administer care to a veteran, regardless of where in the U.S. a provider or veteran is located, including care across state lines or outside a VA facility. In addition, VA providers may use the VA Video Connect software platform to furnish care to a veteran anywhere in the country, including the veteran's home [13, 14]. While providers working in a federal system have the ability to practice throughout the U.S. without licensure in each state of practice, such providers may not only need to adhere to law for their state(s) of licensure, but also the states from which they and a patient are located. However, "laws, rules, regulations, or other requirements are preempted to the extent such State laws conflict with the ability of VA health care providers to engage in the practice of telehealth while acting within the scope of their VA employment" [13, 14].

**Indian Health Service Practice** The IHS' Internet Eligible Controlled Substance Provider Designation policy enables IHS, tribal, or urban Indian organization health care providers to apply for designation by IHS as an Internet Eligible Controlled Substance Provider, which permits providers to prescribe controlled substances for medication-assisted treatment through telemedicine. The policy also allows IHS-designated providers to engage in medication-assisted treatment over telemedicine when a patient is not in the presence of a DEA-registered practitioner and regardless of their facility's DEA registration status [15]. However, medical licensure requirements vary based on whether providers are federal employees assigned to a tribal program or professionals employed by a tribe. Federal employees are bound by federal requirements, whereas tribal employees should obtain the view of their appropriate licensing board in writing [16].

## Conclusion

Early adopters have helped diminish many of CVT's technical barriers, but administrative and regulatory hurdles remain. As

one ascertains from the review presented, the precise way that providers tackle the practical and regulatory considerations for teleprescribing depends on their individual circumstances. Notably, the location of patient and provider and nature of prescribed medications, controlled or non-controlled, all influence the CVT pathway. Moreover, administrative and regulatory requirements present unanticipated, sometimes unintuitive hurdles, and providers face a dynamic, changing, and evolving telehealth landscape.

Navigating the labyrinth of overlapping, sometimes contradictory federal, state, and health care system regulations appear to many as an insurmountable hurdle. This is not a new phenomenon. The introduction of every new technology inspires a reflexive reaction, often from regulators and administrators motivated by a desire to protect the safety and security concerns of the general public. However, it is incumbent upon medical practitioners to respond appropriately when this pendulum swings too far to the detriment of care delivery. In the present context, once practitioners understand the regulatory and operational framework they confront, it behooves them to champion policies that advance the adoption and impact of CVT.

From an operational context, we are still overcoming the aftereffects of the medical field's tacit acceptance that time spent with a patient at distance, beginning with the telephone, is non-reimbursable. This has led to unnecessary delays in treatment, as billing requirements may force a patient to present to an office for in-person medical evaluation when care might have been rendered remotely. Providers should also note other potential intrusions into the physician-patient relationship. For instance the notion of "consent for telemedicine" comes into question as CVT moves from novelty to routine practice. Just as providers do not consent a patient every time they speak over the phone, in the same way, when meeting by CVT, it is clear to all parties how the clinical session is being conducted. An opt-out rather than opt-in consent approach may be more sensible.

Despite the challenges, CVT will play an increasing and ever more instrumental role in the delivery of care, including teleprescribing of controlled substances. To the degree that administrative and bureaucratic challenges can be minimized and understood, the advance of telehealth technologies into clinical settings will continue apace. However, those who seek to see this transformation must remain publicist and promoters of these tools to their peers. They must also be advocates to streamline the restraints and regulations that define the practice of CVT, while mindful of the relevant risks.

## Compliance with Ethical Standards

**Conflict of Interest** The authors declare that they have no conflict of interest.

**Human and Animal Rights and Informed Consent** This article does not contain any studies with human or animal subjects performed by any of the authors.

**Disclaimer** The contents do not represent the views of the US Department of Veterans Affairs or the US Government.

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