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Telehealth in Rehabilitation Psychology and Neuropsychology

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KEYWORDS
- Telepsychology
- Teleneuropsychology
- telehealth
- Rehabilitation
- COVID-19

KEY POINTS
- Although telepsychology had been in use for many years with good clinical and research outcomes, the demand for safety during the COVID-19 pandemic accelerated the implementation of telehealth platforms and solidified their value in providing rehabilitation psychology care.
- Successful use of telepsychology for rehabilitation care requires close communication between administrative staff, patients, caregivers, and providers, including education, skills training, developing efficient workflows, on-the-spot problem solving, and back-up plans to ensure the safety of all involved.
- Developing clear guidelines and screening processes is essential for identifying problems with patient access, technology capability, and clinical appropriateness, particularly for high-risk populations, such as patients with substance abuse and suicidality.
- Teleneuropsychological evaluation offers an innovative and feasible alternative to traditional in-person examination, although remote in-home evaluations are limited in the scope of testing and diagnostic conclusions.
- Continued use of telepsychology will be predicated on the development of sustainable billing and coding practices that reflect the complex aspects of rehabilitation psychology and neuropsychology care.

Major health crises often set the stage for needed reform in medicine and social services by illuminating underlying structural problems that have previously existed but gone largely unaddressed. These catastrophic events offer a unique opportunity to examine barriers to health care provision and enact necessary change for the betterment of patient care. The COVID-19 (coronavirus) pandemic has served as one such reckoning. Both nationally and internationally, one of the key pandemic responses was to postpone elective procedures and services in order to limit the spread of infection.

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Phys Med Rehabil Clin N Am 32 (2021) 405–418
https://doi.org/10.1016/j.pmr.2020.12.009
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Although necessary and beneficial, this dramatic shift also exposed many problems in the US health care system, including limited access to affordable care, exacerbated impact on underserved populations, lack of insurance coverage because of widespread unemployment, deficits in technology infrastructure, cost inflation, and antiquated payment structures. These challenges are substantial and no more apparent than in the field of behavioral health care.

Past studies of epidemics such as the Ebola virus have shown that the prevalence of mental health concerns exceeds the prevalence of infection. In addition, the mental health implications can last longer and have a more pervasive impact on the population. Preliminary data from the COVID-19 pandemic indicate a similar trend, with an exacerbation of symptoms in individuals with pre-existing psychiatric conditions and the development of significant stress in individuals with no premorbid psychiatric history.

The COVID-19 pandemic has also brought into stark relief the disparity between demand and supply in behavioral health care. Epidemiologic studies confirm that in any given year 25% of the American population may experience mental illness, with a lifetime occurrence as high as 57%. Yet, there are demonstrated shortages of behavioral health professionals in many areas of the United States. As of 2018, over 115 million people lived in designated health professional shortage areas, in which the ratio of professionals to residents was less than 1 professional per 30,000 population. Shortages are more likely in rural regions because of lack of infrastructure, funding, and provider supply. This service gap increased dramatically during the pandemic, as many providers closed in-person services. Given the increase in demand for behavioral health services, telepsychology is one means by which the safety and wellbeing of patients and providers can be ensured, while maintaining the necessary safety precautions to limit infection transmission.

TELEPSYCHOLOGY SERVICE

Telepsychology has been in existence for many years prior to the onset of the COVID-19 pandemic. Beginning as early as the mid-1970s, behavioral health professionals began utilizing phone-based telehealth to address the needs of underserved populations. With the development of computers, smart phones, and user-friendly video platforms, telehealth options have expanded dramatically. The US Department of Defense and the US Department of Veterans Affairs (VA) became leaders in telehealth clinics for various health care services. Embedded in the development of videoconferencing technology was a surge to disseminate telehealth services to rural and other underserved patients.

Notwithstanding these advances, implementation of telehealth in behavioral health care remained limited until recently because of multiple barriers, including reimbursement, security concerns, and limited provider competency. Medicare and other commercial payers were reluctant to offer reimbursement at a comparable rate for telehealth services. There were also concerns about confidentiality and the ability of both patient and clinician to ensure safety and privacy.

Research indicates that telepsychology is supported both from a financial and treatment efficacy perspective. The cost of telepsychology services has been found to be equivalent to in-person care. Multiple studies have shown that video-and phone-based telehealth service provision is comparable to in-person treatment of a variety of conditions, including depression, PTSD, anxiety, and mild cognitive impairment.

In the field of rehabilitation, a meta-analysis of telephone-based counseling for individuals with newly acquired disability found improved quality of life 12 months later for
adult patients receiving telephone based counseling after stroke and spinal cord injury.\textsuperscript{16} Telepsychology has also been found to be effective with children and families. One study of children with moderate to severe TBI and their families found that telepsychology was rated as equal or superior to in-person interventions.\textsuperscript{17} Cited benefits included increased family motivation, ease of scheduling, attendance, decreased stigma, equivalent therapeutic alliance, progression, and homework completion. Challenges included increased environmental distractions, limited non-verbal cues, and technology disruptions.

Evidence also supports the delivery of cognitive rehabilitation by telehealth for a variety of rehabilitation populations. Telehealth cognitive rehabilitation has been successfully used for combat veterans diagnosed with mild TBI.\textsuperscript{18} A randomized controlled trial indicated that telehealth rehabilitation was effective for older adults with cognitive impairments and dementia, provided that modifications are made for requiring patients or caregivers to manipulate materials.\textsuperscript{19} Myers and colleagues\textsuperscript{9} found that a telehealth psychoeducation-based cognitive rehabilitation program for survivors of breast cancer was associated with adequate program adherence, participant satisfaction, and improved self-report of cognitive functioning.

**TELENEUROPSYCHOLOGY SERVICE**

Extension of health services into rural and underserved areas has been the primary goal of telepsychology services. Remote video-based neuropsychological assessment (teleneuropsychology) has been shown to enhance service access and reduce health care costs for both the provider and patient. Teleneuropsychology has also been shown to demonstrate high patient satisfaction and consumer acceptability.\textsuperscript{20} Additional benefits of teleneuropsychology evaluation include clarification of diagnosis, detection of either unrecognized or unmet mental health needs, delivery of psychological intervention targeting affective disturbance, caregiver education and support, and neurobehavioral wellness strategies designed to optimize healthy living.

Historically, teleneuropsychology utilized a remote in-person model, in which the patient is seen at a location remote to the provider and testing at the remote site is facilitated by a health care assistant who conducts in-person physical and neuropsychological examination procedures with the patient under the supervision of the provider. Barton and colleagues\textsuperscript{21} described the delivery of videoconferencing as a component of their memory disorders clinic at the San Francisco VA Medical Center. Illustration of their approach emphasizes the need for a health care assistant at the designated remote location. Several other studies have demonstrated the feasibility and validity of conducting teleneuropsychology evaluations over video conferencing.\textsuperscript{22–26}

In the advent of restrictions imposed on in-person clinical services during the COVID-19 pandemic, perhaps no other facet of clinical psychology has been as negatively affected as the neuropsychology service. In many hospitals, clinics, and private practices, the gold-standard of in-person evaluation was suspended to allow for development of safety procedures. Providers shifted to remote in-home evaluations, in which the patient is assessed in his or her unsecured home environment and the neuropsychologist is either at home or at his or her office. Remote in-home evaluations provide unique limitations, including control of the patient environment, security of tests administered, and availability of qualitative data.

Many neuropsychological tests do not transfer well from in-person examination to in-home video examination. Therefore, the breadth of tests traditionally available to
the neuropsychologist is narrower, and the neuropsychologist acquires fewer neurocognitive data from which to infer brain dysfunction. Provided there is adequate audio quality on the provider and recipient device, tests in the auditory domain are more suitable for in-home video examination. These include auditory tasks of basic language, attention, learning and memory, and fluid reasoning. Tests that require the patient to physically handle manipulatives create the greatest challenge to test transfer. Screen sharing capability has reduced this problem considerably, but test security issues remain and should be considered prior to such delivery.

Brearly and colleagues conducted a systematic meta-analysis to determine the effect of videoconference-mediated administration on neuropsychological tests, and differences in scores between videoconference-mediated versus on-site administration. Their analyses demonstrated that there was no clear trend toward inferior scores when tests were delivered through remote videoconference. Disruptions in the technology by means of loss of connectivity or audio showed no clear influence on score variability. Moreover, small effects were observed on tests deemed robust to videoconferencing administration because of their lack of timing and repetition. Verbal tasks such as list learning, digit span, and verbal associative fluency were not affected by videoconference administration. Other tests such as clock drawing and the Mini Mental State Exam showed extensive variability between studies, limiting the ability to determine their effect. It was hypothesized that sources of influence outside of videoconferencing were likely to be driving the distribution of scores across settings.

SPECIAL CONSIDERATIONS WHEN STARTING TELEPSYCHOLOGY SERVICES

Referral Question

With new patients, the nature of the referral question generally drives the modality of the initial consultation. For patients referred exclusively for rehabilitation psychotherapy service, the initial intake can usually be completed virtually. Video is preferred, as completing an initial intake without visual cues may result in less than optimal ability to obtain essential information. Referrals for legal purposes or medical care prescreening are much more challenging to complete via telehealth. Many if not most clinicians require an in-person assessment given the high stakes nature of such evaluations, such as psychological assessments for bariatric surgery and implantable pain devices, or neuropsychological evaluations for epilepsy or deep brain stimulation for Parkinson disease.

Provider Competency

All rehabilitation psychology providers utilizing telehealth platforms should possess the basic competencies required for adequate telepractice, including understanding of clinical, technical, ethical, and legal issues. Continuing education is available through key organizations, including the Inter Organizational Practice Committee, the American Psychological Association, and others.

In cognitive evaluation, an important distinction should be made in the labeling of examination services. Block and Johnson-Greene provide a clarification between cognitive screening, cognitive testing, and neuropsychological assessment. These practices are often incorrectly used interchangeably, whereas the distinction is critical for determining who conducts the remote evaluation and what is being done. Although telehealth cognitive screening and abbreviated testing can be conducted by medical and other rehabilitation providers, neuropsychological assessment should be the sole domain of the clinical neuropsychologist (Table 1).
| Level of Evaluation | Complexity | Specialty | Training | Scope | Examples |
|---------------------|------------|-----------|----------|-------|----------|
| Cognitive screening | Low – no contextual information and scores interpreted in isolation | Licensed and trained health care providers (physicians, physician assistants, SLPs, registered nurses, nurse practitioners, psychologists, neuropsychologists) | Low – entry level licensed health care providers | Narrow – cursory; emphasis on global cognitive functioning | MMSE, MoCA, CLOX, Min-Cog |
| Cognitive testing   | Medium – normative adjustments made; little contextual information | Non-neuropsychologists, speech pathologists, other licensed health care providers working in neurology or rehabilitation settings where cognition is an issue | Medium – familiarity with principles of neurocognition and neuropsychology based on formalized education or training in neuropsychology | Circumscribed cognitive domains in absence of deeper probing and other contextual factors | DRS-2, RBANS; WAIS/WISC; WMS |
| Neuropsychological assessment | High – demographic adjustments; qualitative contextual information | Clinical neuropsychologist | High – specialized internship and 2 years of fellowship training in clinical neuropsychology according to Houston criteria | Comprehensive – integration of cognitive, emotional, behavioral domains in setting of contextual factors | Fixed or flexible batteries including psychological and neuropsychological measures; qualitative neurobehavioral observations |

Adapted from Block CK, Johnson-Greene D, Pliskin N, Boake C. Discriminating cognitive screening and cognitive testing from neuropsychological assessment: implications for professional practice. Clin Neuropsychol. 2017;31(3):487-500. https://doi.org/10.1080/13854046.2016.1267803; with permission.
**Patient Accessibility**

Although research and anecdotal evidence suggest that most patients transition reasonably well to video-based telepsychology, certain populations are likely to have greater difficulty, including older patients and patients with limited technology familiarity or Internet access. With patients who have less reliable Internet access, the telephone is a necessary back up option. The American Psychological Association (APA) Committee on Aging identified several barriers to successful telehealth with older adults. Although 7 in 10 older adults have access to computers, only 11% were comfortable with the telehealth platforms currently available. Older adults may also present with sensory, motor, or cognitive issues that impede their ability to utilize a telehealth platform, especially with audio-only telehealth options. These barriers to care can be lowered by recruiting caregivers and providing front-end training and support in advance of clinical appointments. The APA Office & Technology Checklist for Telepsychology Services is a useful guide for screening patients for potential remote-based services (Table 2).

**Informed Consent**

Informed consent for any psychology service should be obtained at initial contact when feasible. Initial consent should be obtained in writing, with either a signed form or indication via email or telehealth platform. Providers should discuss privacy, security, and limits of telehealth platforms including loss of service, back up options, and data cost for video platforms. With each encounter, a verbal consent to the telehealth platform is recommended and should be documented in each encounter note. Consenting individuals to psychological assessments such as teleneuropsychology evaluation requires an additional level of care. The IOPC has devised foundational elements to informed consent, and these include, but are not limited to:

- Standard test administration will be modified, and this may affect results in ways that are so far unknown, thereby reducing confidence in diagnostic conclusions and recommendations for treatment.
- Involvement of a third-party in the evaluation (eg, caregiver, guardian, parent, and facilitator) may add additional validity concerns.
- Error may be compounded when assessment procedures are used with people who come from culturally and linguistically diverse populations, require an interpreter, or have limited experience or comfort with the technology.
- There will be a loss of some qualitative data usually obtained during an in-person examination, and this loss may reduce the richness of the clinical data and further limit conclusions and recommendations.

**Interstate Practice**

With the mobility provided by telehealth services, rehabilitation providers and patients may either purposely or inadvertently be located across state boundaries. States vary in the specific regulations on telepsychology services and provisions for out-of-state clinicians, which can limit services across state lines. Providers should be familiar with the regulations in their state of practice, as well as other state regulations if their patient resides across state lines.

In order to reduce this service barrier, the APA has worked with state licensing boards to provide cross-state licensing processes and practices with the launch of the Psychology Interjurisdictional Compact (PSYPACT). Formed in February 2015 by the Association of State and Provincial Psychology Boards (ASPPB), PSYPACT was created to facilitate interstate telepsychology and temporary in-person
psychology services. As of May 2020, PSYPACT legislation has been enacted in 14 states: Arizona, Colorado, Delaware, Georgia, Illinois, Missouri, Nebraska, Nevada, New Hampshire, Oklahoma, Pennsylvania, Texas, Utah, and Virginia.

**Group Psychotherapy**

Group psychotherapy via telehealth requires unique considerations. All patients should be screened individually, either in person or via video format, prior to initiation of the group. The purpose and goals of group treatment should be made explicit, and consent to this form of treatment should be obtained prior to enrollment. Patients must verbally consent to their email information being available to other group members to allow access to the video platform. Patients should also be encouraged to access via computer if at all possible as it allows them to see all the members simultaneously, which is more challenging on cell phone platforms generally.

| Table 2                                                                 |
|-------------------------------------------------------------------------|
| American Psychological Association Office & Technology Checklist for Telepsychology Services |
| **Screening**                                                           |
| - Screen patient’s cognitive status.                                    |
| - Assess for adequate technology/comfort level.                        |
| - Evaluate privacy and safety.                                         |
| - Determine necessity for guardian or caregiver.                       |
| **Technology**                                                         |
| - Is the psychologist’s technology platform consistent with HIPAA-(Health Insurance Portability and Accountability Act) complaint practice? |
| - Is there a business associate agreement with the vendor?              |
| - Confirm adequate internet connectivity                                |
| - Confirm secure Internet connection.                                   |
| - Confirm that security protection software is up to date.             |
| - Establish log-in protocol.                                           |
| **Set-up**                                                             |
| - Ensure private location.                                             |
| - Ensure adequate lighting.                                            |
| - Ensure good camera positioning.                                      |
| - Ensure adequate picture and audio quality.                           |
| - Maintain eye contact and articulate clearly.                         |
| **Before the session**                                                 |
| - Discuss risks and benefits with the patient.                        |
| - Get signed informed consent (electronic signatures are sufficient).  |
| - Discuss backup plan when technological problems arise.              |
| - Discuss billing.                                                     |
| - If evaluating a minor, determine where the adult guardian will be.   |
| **Beginning of virtual session**                                       |
| - Verify patient identity.                                             |
| - Verify the patient in view of the camera.                            |
| - Confirm location and phone number where the patient can be reached.  |
| - Review importance of privacy at both locations.                     |
| - Confirm that the evaluation is not being recorded.                   |
| - Turn off all applications and notifications on smart device or computer. Ask the patient to do the same. |
| - Conduct evaluation or intervention as with an in-person session.     |

Data from American Psychological Association. Office and technology checklist for telepsychology services. March 2020. Accessed 09/20/2020.
Risk Management

Although there is substantial literature supporting the use of telehealth with a wide variety of patient populations and treatment modalities, historically these studies have not included high-risk patients, such as those with severe mental illness or suicidal behavior. The limited evidence suggests that telepsychology can be used appropriately with high acuity populations, such as individuals experiencing interpersonal abuse, suicidality, and other emergent situations. Telehealth platforms have been found to enhance patient satisfaction and safety with collaborative development of safety plans. There is also evidence that telepsychology services can reduce repeat hospitalization rates and increase treatment adherence.

Practice guidelines for managing suicidality via telehealth have been published by multiple government and professional organizations, including the APA, the joint task force of the American Psychiatric Association and American Telemedicine Association (Practice Guidelines), the VA, and the US Department of Defense. Guidelines recommend careful screening to determine appropriateness of telehealth platforms, identifying emergency contact and nearby resources, and assessing cognitive capacity, history of cooperation, substance and psychiatric history, and history of violence or self-destructive behavior. Providers should routinely confirm the location of the patient at each visit, to allow for rapid access to emergency services in the event of a crisis. High acuity patients should have a patient-specific emergency plan. Incorporating family members in the care plan can facilitate safety.

Coding and Billing

Historically, the paucity of reimbursement by insurance providers has proven a barrier to provision of telepsychology services. Prompted by the demand for services during the COVID-19 pandemic, as of May 2020 the Centers for Medicare and Medicaid Services (CMS) approved all psychology and neuropsychology codes for video telepsychology. Billing coverage continues to vary state-by-state, and it is unclear to what extent expanded coverage for telepsychology services will remain once the COVID-19 pandemic resolves. State-specific billing code coverage can also be accessed through the IOPC Web site. Interested readers are referred to the APA also provides data on the specific CPT codes and billing recommendations for telepsychology services.

ADAPTATION TO TELEPSYCHOLOGY DURING COVID-19

Several recently published research articles confirm that the greatest barriers to use of telehealth services before the pandemic were clinicians themselves, who felt uncomfortable with virtual platforms and lacked adequate training to use telehealth platforms effectively. Additionally, psychologists demonstrated a negative bias against telehealth platforms despite many years of research supporting the claim that telepsychology is no less effective than in-person treatment with a wide variety of patient populations and conditions.

The transition to telepsychology during the COVID-19 pandemic has been remarkable. A study completed in August 2020 looked at telehealth service provision by a cross-section of 2600 psychologists around the country. It found that before the pandemic, 7% of psychological services were rendered virtually, whereas telepsychology increased twelvefold to 85% during the pandemic. Psychologists were optimistic that they could continue to provide about one-third of their care in a virtual format even after pandemic restrictions were lifted.
In June 2020, a case example was published of the rapid transition to telehealth in a primary care psychology service. Within a 2-week window, the service moved to an entirely virtual format. Facilitating factors included a pre-existing telepsychology platform and policies related to an existing research project. Challenges included limited clinic capacity for telehealth service, decreased referral volume, scheduling and electronic health record access from remote sites, technology disruption, and patient preference.

A CASE EXAMPLE OF RAPID TRANSITION TO TELEPSYCHOLOGY SERVICE

VCU Health is a large Level 1 trauma center and academic medical center located in Richmond, Virginia. The health system serves a diverse patient population uniquely characterized by a high volume of urban and rural residents. Of the 840,000 plus outpatient clinic visits in 2019, only a fraction were provided by telehealth. As of early March 2020, all rehabilitation psychology and neuropsychology services in the Department of Physical Medicine & Rehabilitation (PM&R) were provided in-person, with no established platform for telepsychology services.

On March 12, 2020, the health system elected to reduce and redefine ambulatory services in order to limit COVID-19 transmission. In-person ambulatory services were reduced to 20% of normal volume, and widespread telehealth was implemented. By April 2020, consistent with other sectors of VCU ambulatory care, 90% of VCU PM&R psychological services were provided virtually. Throughout the shelter-in-place months of April, May, and June, 80% to 90% of all services were rendered virtually by video platform or telephone. With the establishment of safety procedures for in-person services and stabilization of infection rates, in-person psychology services increased gradually through the summertime (Fig. 1).

This case example illustrates that rehabilitation psychology services care can be maintained even with an abrupt transition to telehealth service. Without an established telepsychology platform, the rapid transition from in-person to virtual services required agility by providers, patients, and administrators. During the emergent ramp-down phase, providers maintained close contact with patients by phone or available videoconferencing technology such as FaceTime. A formal triage system was developed to identify patients who would be best served by telepsychology,
which required extensive training of providers and support staff. Communication between staff, providers, and patients was integral, with office staff playing a critical role in information dissemination. Patients were provided with education on using the telehealth platform in advance of their first appointment and were provided with a backup option should the first platform fail. Multiple HIPAA-compliant video telehealth platforms were trialed, including Zoom, Doximity, and Connect Well. Due to easier facilitation of group psychotherapy, Zoom was implemented for all rehabilitation telepsychology services. With the exception of comprehensive neuropsychological evaluations, all psychological services were able to be provided via telehealth, including

- Neurobehavioral status examination
- Psychiatric diagnostic interview
- Treatment consultation
- Abbreviated neuropsychological assessment
- Psychological assessment
- Group psychotherapy
- Cognitive behavioral therapy
- Acceptance and commitment therapy
- Affect processing therapy
- Motivational interviewing
- Relaxation training
- Lifestyle change and management
- Psychoeducation

Patient feedback suggests that although not optimal, telepsychology services provide a safe option for continued services when in-person rehabilitation services are not feasible. Many patients find it more convenient to be able to be seen in their homes. For some rehabilitation patients, the telehealth is the only means for access because of transportation limitations and other barriers to care. As one patient observed, “it would not be possible for me to attend in person sessions even if (the therapist) were allowed to do so. Also, it has been a blessing to be able to still have interaction with (the therapist) and the members of the group on a regular basis. Even with the occasional technical glitches, being able hear from and talk to the others in the group is better than not communicating at all.” Other patients have reported less than optimal experiences, owing to issues of confidentiality, intimacy, and familiarity. As observed by another patient, telehealth “has been wonderful, because we have been able to keep up within our group with most issues for group members. On the down side, …not having a place to meet, to get out of the house and see each other, have a place to go that is private, has made personal sharing harder and feedback more stilted. Not to mention the camaraderie that is essential to group is missing, the personal touch of eye to eye, direct feedback is gone.”

FUTURE DIRECTIONS

The use of telehealth in response to the COVID-19 pandemic has resulted in dramatic changes in the way rehabilitation psychologists and neuropsychologists provide services. Guidelines for clinical care, risk management, maintaining an ethical practice, test security, and billing have been published on numerous practice organization Web sites and training webinars. Prior research indicates that telepsychology can be used to successfully provide psychotherapy and cognitive rehabilitation services to various rehabilitation patients, including SCI, TBI, stroke, and dementia.
Moving forward, continued efforts to ensure adequate insurance reimbursement for these types of services will be essential. In the field of psychology, most billed services are timed, and the need for compatible payment for timed services will need to be taken into account to ensure fair reimbursement. The current temporary provisions suspending requirement of in-person service provision and HIPPA-compliant platforms will need to be replaced with more permanent solutions for coding and billing.

Studies have also demonstrated the feasibility and validity of administering neuropsychological evaluations via video conferencing. More work is needed to demonstrate the validity of conducting teleneuropsychology in uncontrolled patient settings and developing methods for the remote use of manipulatives for motor and visuospatial assessment. Using traditional nineteenth century evaluation methods in remote evaluations is difficult, which further serves as motivation for the evolution of orthodox and novel technologies. The goal of the Disruptive Technologies Initiative of the American Academy of Clinical Neuropsychology is to embrace novel methods in engineering, computer programming, and biotechnology so that the next generation of neuropsychologists is at the forefront of informing rather than reacting to technological innovations and health care crises. Further lobbying for continuing reimbursement of remote neuropsychological services will potentially serve to redefine the way in which a typical neuropsychological evaluation is conducted.

It is too early to tell if the rapid transition to telepsychology will be sustained over time. Uncertainty remains regarding whether the reimbursement of telehealth services will be reversed or integrated into broader health care reform. Although there are limitations to telepsychology, there are also clear advantages that were identified during the COVID-19 pandemic, including supporting continuity of care, facilitating service access, and maintaining patient and provider safety. The case study of the VCU Health PM&R psychology service illustrates that rapid and dramatic changes can be successfully executed when transitioning to telehealth. Additional research and clinical care evaluation are being conducted daily, and there is good reason for optimism regarding the future role of telehealth in the provision of rehabilitation psychology and neuropsychology care.

**CLINICS CARE POINTS**

- The specific referral question is a major determining factor in assessing appropriate use of telehealth for both initial assessment and follow-up treatment.
- Providers require tailored training in the technical use of the telehealth platforms and how to conduct an assessment via video, including an appreciation of limits to data collection and diagnostic accuracy.
- Informed consent for use of the telehealth format must be obtained at initial consultation and for each subsequent treatment session. Written consent should be obtained through some form of electronic documentation.
- Careful screening of high-risk patient populations is imperative, with clear documentation of risk assessment and clarification that use of telehealth platforms may need to be altered or discontinued based on ongoing risk assessment and changes in clinical presentation.
- Group psychotherapy can be provided via telehealth platforms that allow for multiple participants. Patients being considered for group psychotherapy service provision will require individual assessment prior to initiation of this form of treatment.
- Remote neuropsychological testing presents unique challenges and may result in reduction in diagnostic confidence and validity by introducing additional error variance.
Reliance on validated measures and adhering to established guidelines when conducting a remote assessment are strongly recommended.

At present, the Centers for Medicare and Medicaid have suspended most prior limits for telepsychology billing, but this is likely to change in the near future. Attention to ongoing changes is essential in order to maintain compliance.

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