



**AMERICAN  
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SERVICES, INC.

March 18, 2025

Derek S. Maltz  
Acting Administrator  
U.S. Drug Enforcement Administration  
8701 Morrisette Drive  
Springfield, VA 22152

Re: **Docket No. DEA-407, Special Registrations for Telemedicine and Limited State Telemedicine Registrations**  
*Submitted electronically via Regulations.gov*

Dear Administrator Maltz,

On behalf of American Psychological Association Services Inc. (APA Services), I would like to offer the perspective of our prescribing psychologists in response to the proposed rule **Special Registrations for Telemedicine and Limited State Telemedicine Registrations (Docket No. DEA-407)** (hereinafter, “Proposed Rule”), as well as its companion Final Rule titled **Expansion of Buprenorphine Treatment via Telemedicine Encounter (Docket No. DEA-948)** (hereinafter, “Final Rule”). APA Services is the companion organization of the American Psychological Association, which is the nation’s largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 173,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

While the vast majority of all prescribers, including the approximately 400 psychologists currently authorized to prescribe, act ethically and responsibly in their practice, APA Services understands the need for effective protocols preventing the unlawful diversion of controlled substances. However, rather than providing practicable guardrails, the rules would arbitrarily impede access to comprehensive behavioral health care for many patients and disproportionately burden the many law-abiding clinicians who are simply trying to serve their communities by providing much-needed services in an ethical, effective, and safe manner.

As discussed below, APA Services requests that the Trump Administration:

1. Rescind the Proposed Rule and engage in a new round of rulemaking after engaging in a dialogue with prescribing behavioral health clinicians, consistent with existing Administration policy;<sup>1</sup> and

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<sup>1</sup> Executive Order: Regulatory Freeze Pending Review (January 20, 2025),  
<https://www.whitehouse.gov/presidential-actions/2025/01/regulatory-freeze-pending-review/>



2. Delay implementation of the Final Rule to ensure it harmonizes with a new proposed rule on the Special Registration criteria and process.

With over 122 million Americans residing in mental health professional shortage areas,<sup>2</sup> the power of telehealth to extend the reach of mental and behavioral health practitioners cannot be understated. Thanks to certain administrative flexibilities under the first Trump Administration, many more Americans—particularly those who face daunting challenges to accessing in-person treatment—can access early and preventive treatment for mental and behavioral health conditions. Psychologists’ practices have responded favorably to these changes as well, with approximately 7 in 10 psychologists utilizing a hybrid practice that offers both in-person and telehealth services.<sup>3</sup>

Psychologists are experts credentialed in the field of psychological science and practice. To obtain state licensure to practice as a psychologist, psychologists must generally complete a doctoral degree in psychology, finish two years of supervised experience, and pass a licensure exam.<sup>4</sup> Seven states—Iowa, Illinois, Louisiana, New Mexico, Colorado, Idaho, and Utah—enacted legislation permitting licensed psychologists to complete a master’s degree in clinical psychopharmacology and supervised clinical practice hours as well as pass at least a national licensure examination to be eligible to prescribe medications common to mental or behavioral health treatment.<sup>5</sup> Psychologists within certain federal agencies like the Department of Defense and the Indian Health Service are also eligible to prescribe after completion of the same educational, practical, and testing requirements.

## **Special Registration Proposed Rule**

### ***Telemedicine Prescribing Registration (Schedules III-V)***

#### ***Interference with Clinical Practice***

The Proposed Rules permit a qualified practitioner with a “legitimate need” under Proposed Rule 21 C.F.R. § 1301.11(c)(2) to obtain a special registration to prescribe via telehealth. Proposed Rule 21 C.F.R. § 1301.13(k)(2)(v) likewise requires an applicant to both “attest that they have a legitimate need for a Special Registration for Telemedicine” and to disclose “the facts and circumstances that form the basis for their legitimate need.”

APA Services is troubled by the DEA’s proposal to assess and determine the “legitimacy” of a practitioner’s decision to treat patients via telehealth. While APA Services understands and shares

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<sup>2</sup> Health Resources and Services Administration (last updated Feb. 4, 2025). Health Workforce Shortage Areas, <https://data.hrsa.gov/topics/health-workforce/shortage-areas>.

<sup>3</sup> American Psychological Association. (2024). *2024 Practitioner Pulse Survey*. <https://www.apa.org/pubs/reports/practitioner/2024>.

<sup>4</sup> Association of State and Provincial Psychology Boards PSYBook: Psychology Licensing Requirements, <http://psybook.asppb.org/>.

<sup>5</sup> American Psychological Association Services, Inc. About Prescribing Psychologists, <https://www.apaservices.org/advocacy/issues/prescriptive-authority/prescribing-psychologists>.



**AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION**  
SERVICES, INC.

the DEA's goal to curb diversion and inappropriate prescribing of controlled substances, APA Services fears this Proposed Rule interferes in the shared decision-making capacity between the patient and provider. Several individualized factors lead a provider and patient to decide whether services will be provided via telehealth.

Some of these factors are practical in nature; for example, a patient may lack transportation or must otherwise travel long distances to access a physical clinic. Some of these factors are clinical in nature; for example, a clinician may wish to see the patient's living environment to gain greater insight into their psychological well-being. Organizations may employ telehealth to distribute scarce provider resources to areas or populations with critical needs. At the end of the day, these decisions are best left to patients and providers, who together are in the best position to select the modality of treatment most appropriate for an individual patient. APA Services sees no role for the DEA in assessing the "legitimacy" of a provider's need to utilize telehealth services, as doing so would intrude on clinical decisions.

### *Inappropriate Guardrails Against Diversion*

These intrusions are especially troubling considering the Proposed Rule's failure to create effective and evidence-based anti-diversion tools. Instead, it mistakenly relies on a patient and provider's in-person interaction as a marker for the "legitimacy" of the prescription. To be clear, prescribing psychologists are under ethical and legal obligations to ensure that the patient receives competent treatment via telehealth,<sup>6</sup> even if that means referring the patient to another provider.<sup>7</sup> However, there is simply no evidence that rates of fraudulent behavior for services provided via telehealth are any higher than they are for in-person visits<sup>8</sup>, or that an in-person visit is an effective check against unlawful diversion of controlled substances.

In fact, the evidence demonstrates that requiring an in-person visit is not an appropriate guardrail for care provided via telehealth, and instead tends to result in lower rates of follow-up care.<sup>9</sup> In April 2024, the Medicare Payment Advisory Commission (MedPAC) heard testimony that

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<sup>6</sup> See, e.g., American Psychological Association (2024). Proposed Revision of Guidelines for the Practice of Telepsychology. Retrieved from <https://www.apa.org/practice/guidelines/telepsychology-revisions.pdf>.

<sup>7</sup> See, e.g., American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, amended effective June 1, 2010, and January 1, 2017). <https://www.apa.org/ethics/code>.

<sup>8</sup> See, e.g., U.S. Department of Health and Human Services Office of Inspector General (February 13, 2024). Medicare Generally Paid or Evaluation and Management Services Provided via Telehealth During the First 9 Months of the COVID-19 Public Health Emergency That Met Medicare Requirements, available at: <https://oig.hhs.gov/reports/all/2024/medicare-generally-paid-for-evaluation-and-management-services-provided-via-telehealth-during-the-first-9-months-of-the-covid-19-public-health-emergency-that-met-medicare-requirements/>

<sup>9</sup> Huskamp, H. A., Uscher-Pines, L., Raja, P., Normand, S.-L. T., Mehrotra, A., & Busch, A. B. (2024). Trends in Use of Telemedicine for Stimulant Initiation Among Children and Adults. *Psychiatric Services*, 75(7), 630–637. <https://doi.org/10.1176/appi.ps.20230421>



**AMERICAN  
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mandatory in-person requirements are “disruptive” to patient care.<sup>10</sup> Even skeptics of telehealth generally have testified that uniform in-person requirements “limit the ability of telehealth to expand access to mental health services for patients who live far from any mental health clinician.”<sup>11</sup>

Instead of creating needless burdens on patients and prescribing providers, APA Services recommends that the DEA focus on creating tools to strengthen its capabilities to conduct appropriate law enforcement, rather than regulating the delivery of health care services. There are numerous examples of other effective guardrails that can be implemented under the DEA special registration framework; for example, the DEA could implement enhanced oversight of organizations prescribing unusually high volumes of controlled substances.

#### *Nationwide PDMP Check*

Proposed rule 21 C.F.R. § 1306.43 requires any Special Registrant to perform a check of the Prescription Drug Monitoring Program (PDMP) in not only the states where the patient and registrant are located, but also “[a]ny state or territory with PDMP reciprocity agreements with [the patient’s and registrant’s state] for data regarding any controlled substance prescriptions issued to the patient in the last year.”

While APA Services understands the rationale behind this proposal, the reality is that this proposal is not feasible given the current information technology infrastructure that exists today. In some states, such as New Mexico, PDMPs cannot be accessed from outside the state at all. Many PDMPs are also not interoperable and do not integrate well with electronic health records systems; as a result, providers tend to find them burdensome to use. Leadership in other federal government agencies is needed to help states modernize and standardize PDMP capabilities to enable a seamless and user-friendly provider check. Only after these issues with PDMP systems are resolved among the states can a mandatory PDMP check like the one outlined in the proposed rule become a feasible means of averting unlawful diversion.

#### *Mandatory Use of Audio/Video Telecommunication System*

Proposed rule 21 C.F.R. § 1306.44(a) also requires any prescriptions issued through the Special Registration process to be via an audio-video communication system. This represents a double standard from the federal government as to the utility and reliability of audio-only telehealth. In the CY 2025 Medicare Physician Fee Schedule Final Rule, CMS allowed Medicare coverage of audio-only telehealth when the patient is receiving services in their homes and the practitioner is

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<sup>10</sup> Medicare Payment Advisory Commission (April 11, 2024), Public Meeting Transcript, 13:19-20, available at: <https://www.medpac.gov/wp-content/uploads/2023/10/April-2024-meeting-transcript.pdf>.

<sup>11</sup> Mehrotra, MD (March 12, 2024), Next Steps in Payment and Regulatory Policy for Telehealth: Before the Committee on Ways & Means, U.S. House of Representatives, available at <https://gop-waysandmeans.house.gov/wp-content/uploads/2024/03/Mehrotra-Testimony.pdf>.



**AMERICAN  
PSYCHOLOGICAL  
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SERVICES, INC.

capable of utilizing an audio/video telehealth system but the patient is not capable of using it or does not consent to using it.

In the Proposed Rule, the DEA appears to partially walk back CMS' findings by implying suspect treatment of audio-only telehealth. In the Final Rule concerning access to buprenorphine treatment for opioid use disorder, the DEA permits prescriptions via audio-only telehealth without apparent controversy, yet provides no evidence or data supporting the need for a different regulatory scheme for other behavioral health medications.

### *Added Costs*

Proposed rule 21 C.F.R. § 1301.13(e)(1) establishes a fee structure for all types of special registrations. Unfortunately, the many layers of registration create unnecessary cost burdens and administrative barriers, particularly for solo and small group practitioners that already face relatively high costs to offer telehealth services in the first place, including licensing fees for telehealth platforms and staff training for new protocols concerning patients seen via telehealth. APA Services instead recommends that all the costs and procedures of the Special Telehealth Registration be folded into the cost and procedure of obtaining a DEA registration to prescribe controlled substances in person.

### *Administrative Burdens on Health Care Providers*

Finally, proposed rule 21 C.F.R. § 1304.04(i) requires all clinicians issuing prescriptions through the Special Registration process to abide by certain documentation requirements, including photographic records for patient verification, and documentation of the date and time of the telemedicine encounter, the address of the patient during the telemedicine encounter, and the home address of the patient. Prescribing psychologists are already subject to an array of documentation requirements under various federal and state laws, some of which may contravene the specific requirement under this proposed rule. Adding yet another set of documentation rules only invites further confusion. Again, the DEA continues to propose additional documentation requirements, without any clear evidence of their likely effectiveness at preventing diversion.

### ***Advanced Telemedicine Prescribing Registration (Schedules II-V)***

#### *Board-Certification Requirement*

Proposed rule 21 C.F.R. § 1306.45 would make certain classes of physicians or board-certified mid-level practitioners eligible to obtain an Advanced Registration and prescribe Schedule II medications. The DEA again appears to be overstepping its mission and regulating the delivery of health care services by weighing the relative educational qualifications of different practitioners, rather than outlining meaningful factors that assess a candidate's fitness concerning ethical prescribing of controlled substances. The extensive education, training, and supervised practice required of prescribing psychologists is sufficient to qualify them to prescribe Schedule II medications via telemedicine without a separate board certification in one of numerous specialties, and the Proposed Rule misunderstands the role of board certification in the practice of psychology.



**AMERICAN  
PSYCHOLOGICAL  
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Established in 1947, the American Board of Professional Psychology<sup>12</sup> (ABPP) is the governing body overseeing a wide array of specialty certifications in psychology, including clinical psychology, clinical child and adolescent psychology, and behavioral and cognitive psychology. A new board certification in psychopharmacology has also been created but is not yet operational. To be eligible for ABPP board certification, psychologists must be licensed by their state, submit their educational credentials and practice samples for review, and pass written and oral examinations. The Final Rule does not specify whether any of the specialties credentialed by ABPP would qualify for the purpose of obtaining an Advanced Special Registration.

While board certification may be the norm for physicians and other providers, it is not as common for psychologists. Board certification is encouraged in the field yet is not required for licensure in any state. Some psychologists opt to obtain Board certification for an array of specific reasons. For some of these psychologists, it eases their mobility for moving from state to state; for others, the credential increases their pay, while certain specific institutions like the Mayo Clinic require board certification for all their psychologist employees. In any event, board certification in psychology is not an effective means of gauging a clinician's ability or willingness to unlawfully divert controlled substances. Instead, it appears to be a requirement that arbitrarily narrows down the numbers of practitioners eligible to prescribe via telehealth.

### *Geographic Restriction*

Proposed 21 C.F.R. § 1306(b) also requires practitioners with an Advanced Special Registration to be physically located in the same state as their patients when the prescription is issued via telemedicine. Telemedicine has expanded access to mental and behavioral health treatment in areas that for generations have faced a shortage. APA Services fears that this “same state” requirement will disproportionately burden residents of rural communities, who on average must travel 40 miles farther than their urban counterparts for access to in-person treatment.<sup>13</sup> Many states have utilized interstate licensure compacts to enable telehealth as a means of bridging access across state lines for rural communities that may be closer to a clinician in a neighboring state than in their own.

### *Limit on Schedule II Medications Via Telemedicine*

Proposed 21 C.F.R. § 1306.45(c) would also limit the average number of Schedule II medications prescribed via telemedicine to less than 50% of the total Schedule II medications issued in the calendar month. This requirement reflects a flawed understanding of how in-person and telehealth treatment interact with one another. While most of our practitioners operate hybrid practices with patients seen in-person and virtually, some practitioners operate entirely remote practices, and this proposed rule would all but exclude those practices. Some appointments made via telehealth are

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<sup>12</sup> American Board of Professional Psychology, About ABPP, <https://abpp.org/about-abpp/>.

<sup>13</sup> U.S. Government Accountability Office (May 16, 2023), Why Health Care Is Harder to Access in Rural America, available at: <https://www.gao.gov/blog/why-health-care-harder-access-rural-america>.



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PSYCHOLOGICAL  
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made on short notice. For example, the patient with an in-person appointment may be experiencing travel difficulties and may request a telehealth appointment; if the provider accepts the telehealth appointment, the practitioner may then have to move a different telehealth appointment to an in-person appointment to meet the sub-50% threshold. Again, APA Services believes the DEA is arbitrarily selecting criteria with little evidence of their likely impact on diversion.

### *State Registration*

In addition to the extensive requirements described above, Proposed Rule 21 C.F.R. § 1301.11(d) also requires practitioners seeking any Special Registration to obtain a State Telemedicine Registration “for every state in which patients to whom special registration prescriptions will be issued are located.” The rule does not articulate the exact function of this requirement, except to clarify that they will also be issued by the DEA and not the individual states themselves. While APA Services appreciates the exemption for officials in the U.S. Armed Forces, Public Health Service, and Bureau of Prisons, APA Services anticipates this requirement will function as a duplication of existing registration requirements that unfairly burden other practitioners who operate multi-state behavioral health practices.

### **Buprenorphine Final Rule**

Finally, APA Services also wishes to convey its position on the Final Rule concerning access to buprenorphine via telemedicine, purportedly effective as of March 21<sup>st</sup>, 2025. Although currently, prescribing psychologists are only eligible to prescribe buprenorphine in one state (New Mexico), our prescribing clinicians in that state require some clarification and refinement of this Final Rule to ensure that patient needs—particularly those in rural and other underserved areas—continue to be met while minimizing the administrative burden on clinicians.

APA Services applauds the DEA for recognizing the “hardships an in-person medical evaluation requirement could cause patients” concerning access to buprenorphine for patients recovering from opioid use disorder. While those concerns are no less true for patients receiving other types of medications for behavioral health treatment, for patients suffering from opioid use disorder, an abrupt discontinuation of buprenorphine treatment is associated with a higher risk of acute psychosis<sup>14</sup> and relapse to illicit opioid use.<sup>15</sup>

Accordingly, APA Services supports the provisions in this Final Rule allowing a DEA-registered practitioner to prescribe an initial six-month supply of buprenorphine via telehealth, whether via audio-only or audio-video telehealth. However, the Final Rule also requires that, before doing so,

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<sup>14</sup> S. Weibel, M. Mallaret, M. Bennouna-Greene, G. Bertschy, 2824 – Acute psychosis and buprenorphine withdrawal: abrupt vs. progressive could make a difference, *European Psychiatry*, Volume 28, Supplement 1, 2013, Page 1, ISSN 0924-9338, [https://doi.org/10.1016/S0924-9338\(13\)77409-1](https://doi.org/10.1016/S0924-9338(13)77409-1).

<sup>15</sup> Zweben JE, Sorensen JL, Shingle M, Blazes CK. Discontinuing Methadone and Buprenorphine: A Review and Clinical Challenges. *J Addict Med*. 2021 Nov-Dec 01;15(6):454-460. doi: 10.1097/ADM.0000000000000789. PMID: 33323695; PMCID: PMC10082633.



the practitioner must first check the prescription drug monitoring program (PDMP) in each state in which the patient was located in the previous year. As discussed above, PDMPs are cumbersome to use and are often not interoperable across state lines. The Final Rule appears to acknowledge these challenges by allowing for more limited 7-day supply intervals but does not address the core access problems with PDMPs and instead gratuitously adds to the practitioner's administrative burden. APA Services recommends that the Agency and its new leadership devote resources towards making PDMPs more efficient and accessible by practitioners, particularly those that provide services in multiple jurisdictions.

Beyond the initial six-month supply period, the prescribing practitioner must either conduct an in-person medical evaluation or continue to practice telemedicine under one of the Ryan Haight's narrow exemptions. The Final Rule does not clarify the nature of this "medical examination," and whether it can be conducted through a model of integrated care, which is a rapidly emerging form of interdisciplinary, team-based care that integrates behavioral health treatment into primary care and other medical settings.<sup>16</sup> Moreover, the Final Rule continues to rely on a practitioner's "in-person" presence as a guardrail against diversion; as articulated in greater detail above, there is no evidence that requiring a practitioner to provide services in-person has any impact on inappropriate diversion of medications.

If the practitioner cannot conduct such a medical evaluation, the Final Rule appears to be interdependent on the Administration's finalization of the Proposed Rule concerning the Special Registration criteria described above, with the exception of telemedicine practice that falls within the Ryan Haight Act's other narrow exemptions. Given our concerns with the Proposed Rule described above, APA Services sees this as a critical access issue, as it introduces a new barrier to treatment for patients who have received remote care over the past several years.

In turn, this risks an arbitrary termination of access to opioid use disorder treatment, resulting in a higher risk of relapse or aggravating another mental health condition. The potential for a six-month "access cliff" is also contrary to scientific evidence, which has found that longer-term access to buprenorphine treatment can have improved clinical benefits.<sup>17</sup> As a practical matter, this six-month cutoff period may result in clinicians selecting only patients with the ability to travel to an in-person appointment, leaving other patients with fewer options for evidence-based care.<sup>18</sup>

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<sup>16</sup> Miller-Matero LR, Dykuis KE, Albujoq K, Martens K, Fuller BS, Robinson V, Willens DE. Benefits of integrated behavioral health services: The physician perspective. *Fam Syst Health*. 2016 Mar;34(1):51-5. doi: 10.1037/fsh0000182. PMID: 26963777.

<sup>17</sup> Daniel Rutrick, Susan M. Learned, Brent Boyett, David Hassman, Sunita Shinde, Yue Zhao, 18-Month efficacy and safety analysis of monthly subcutaneous buprenorphine injection for opioid use disorder: Integrated analysis of phase 3 studies, *Journal of Substance Use and Addiction Treatment*, Volume 154, 2023, 209155, ISSN 2949-8759, <https://doi.org/10.1016/j.josat.2023.209155>.

<sup>18</sup> Moran, M. (2023). APA Urges DEA to Expand Telemedicine Prescribing. *Psychiatric News*, 58(09). <https://doi.org/10.1176/appi.pn.2023.10.10.53>



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Last year, the DEA extended the current regulatory waivers on tele-prescribing through the end of 2025, which appears to now be at odds with the Final Rule's effective date of March 21<sup>st</sup>, 2025. APA Services requests a further delay in implementing this Final Rule, and further clarification of its provisions pertaining to in-person medical evaluations. Ideally, the effective date of the Final Rule and the Proposed Rule would be identical, as practitioners relying on the Special Registration process to prescribe buprenorphine after the initial six-month period outlined in the Final Rule would have a clearer transition to new regulatory criteria.

Thank you for the opportunity to weigh in on these rules. Expanded access to tele-mental and tele-behavioral health treatment is a major legacy of the first Trump Administration and represents a key opportunity to expand access to care among rural and other underserved communities that have long struggled to meet their behavioral health needs. APA Services calls on the second Trump Administration to preserve that legacy, modify these rules, and engage in a new round of rulemaking after meaningful engagement with clinicians to fully understand the challenges and prospects that lay ahead for providers offering services via telehealth. Please contact Andrew Strickland, J.D., Senior Legislative and Regulatory Officer at [astrickland@apa.org](mailto:astrickland@apa.org) if our organization or members can be of any assistance to the Administration.

Sincerely,

Katherine B. McGuire  
Chief Advocacy Officer  
American Psychological Association Services, Inc.