

Variation across state laws that could facilitate the use of telehealth for ADHD or Tourette syndrome diagnosis, monitoring, or treatment

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Lauren M. Langan, JD
 Logan M. Hamilton, MPH

Introduction

For children with attention-deficit/hyperactivity disorder (ADHD)¹ or Tourette syndrome (TS)² to receive appropriate care, clinical guidelines recommend an accurate diagnosis and an individualized treatment plan.^{3,4} Diagnosis and treatment for either ADHD or TS involve frequent interactions with the health care system and medical professionals, and may include psychological/behavioral treatment or pharmacological treatment, or both.³ The medications most commonly used to treat ADHD are Schedule II prescription stimulants, which require re-authorization every 90 days.^{3,5,6} Behavioral treatment, such as comprehensive behavior intervention for tics (CBIT) or parent training for parents of children with ADHD, may require regular, frequent visits with the treating professionals.^{3,5}

Health care providers have increasingly used new technologies to deliver virtual health services — known as telehealth — including behavioral and pharmacologic services.⁷⁻¹⁰ Telehealth can increase access to specialty care, including psychiatry and neurology, in communities with shortages of health care professionals, including rural areas.¹¹⁻¹⁴ It can also increase access for patients who have challenges with time, mobility, and transportation,⁷ or provide access to medical treatment that is feasible for people with executive function challenges. Executive function challenges, which are common for people with either ADHD or TS,^{15,16} can interfere with scheduling and keeping appointments,¹⁷ and telehealth can potentially decrease those burdens.

About half of people with ADHD utilize telehealth for their ADHD care, with the rate of children accessing treatment for ADHD via telehealth falling slightly below half.^{18,19,20} Health insurance or Medicaid restrictions on the telehealth services for which reimbursement may be made²⁰ and state licensure requirements that limit providers' use of telehealth as a mode of care serve as major barriers to health care providers' adopting or increasing the use of telehealth services for children, especially children with ADHD or TS.²² State laws regulating telehealth services can create guardrails designed to ensure quality care, while also facilitating or hindering access to ADHD and TS diagnosis and treatment.²³ This policy brief summarizes key findings and recommendations based on a legal landscape assessment of state laws regulating reimbursement for telehealth services and medical professional interstate licensure requirements, and a rapid assessment of evidence evaluating the direct effects of those laws on ADHD or TS diagnosis or treatment.

Methods

Findings and recommendations presented in this policy brief are based on a legal landscape assessment of state laws regulating telehealth services, including restrictions related to Medicaid and private payor reimbursement, and interstate health care provider licensure, as well as a rapid assessment of the evidence evaluating the effects of those laws on ADHD and TS diagnosis and treatment. Both assessments were conducted by a research team consisting of two attorneys with expertise in legal research and policy analysis and one legal intern.

The legal landscape assessment used a combination of primary and secondary source research to identify and summarize laws across all 50 U.S. states and the District of Columbia. Primary research using the Westlaw Advantage database and secondary research using publicly available resources were originally conducted in April 2025 and updated in June 2026. Secondary sources included resources developed by the Center for Connected Health Policy, Foley & Lardner LLP, the National Conference of State Legislatures, and the Psychology Interjurisdictional Compact Commission. For areas where secondary sources were used to summarize the legal landscape, the date of the source’s most recent update is provided, which ranged between April 2024 and September 2025.

Specific state laws highlighted throughout this policy brief, including in tables, were selected to demonstrate variation in policy approaches and are not intended to represent all state policy environments. These examples illustrate key features of the broader telehealth legal landscape but do not provide a comprehensive summary of laws in every state.

To identify relevant evidence regarding the effects of state telehealth laws on pediatric ADHD or TS outcomes, the research team conducted PubMed searches for published studies examining telehealth diagnosis, treatment, and outcomes for ADHD and TS, as well as laws that impact telehealth treatment or ADHD or TS outcomes. Searches were initially conducted by the research team in April 2025 and updated in June 2026.

The goal of this policy brief is to summarize the current legal landscape and available evidence based on legal, policy, and scientific resources reviewed at the time of the assessments.

Legal Landscape Assessment

Medicaid Reimbursement for Telehealth ADHD and TS Services

All 50 states and DC provide Medicaid reimbursement for at least some forms of live video telehealth services. These state laws vary regarding the restrictions on patient location while engaging in telehealth services, types of clinicians permitted to provide telehealth services, and types of services permitted to be provided via telehealth²⁴ — each of which might impact coverage for ADHD and TS telehealth services.

As of September 2025, 16 states and DC included a list of permitted originating sites for telehealth service utilization.²⁵ The originating sites included on these lists can be specific, such as within certain qualified health care facilities, or broad, such as “any location determined by the individual receiving the service” (see Table 1).

Table 1. Examples of state laws regulating originating sites eligible for Medicaid telehealth reimbursement, as of June 2026.

	TENNESSEE	WASHINGTON	NEW YORK
SUMMARY OF LAW	Defines telehealth to include only when the patient is at certain health care offices/facilities or certain school facilities.	Defines originating site for telemedicine to include certain health care facilities, a home, or any location determined by the individual receiving the service.	Includes place of service codes for telehealth services provided in certain health care facilities, the patient’s home or private residence, or a location other than the patient’s home.
LOCATION OF LAW	Tenn. Code Ann. § 56-7-1002(a)(5), (a)(7)(A)	Wash. Rev. Code § 74.09.325(3)	Telehealth Policy Manual. New York State Medicaid Fee-for-Service Provider Policy Manual, Version 2026-V1. ²⁶

State laws also vary regarding the types of providers eligible for Medicaid reimbursement for telehealth services.²⁵ While some states limit eligibility to a specific list of types of providers, other states require appropriate licensure, enrollment, and scope of practice without limiting the types of providers eligible to provide telehealth services (see Table 2).

Table 2. Examples of state laws regulating health care providers eligible for state Medicaid reimbursement of telehealth services, as of June 2026.

	NORTH CAROLINA	MAINE	ARIZONA
SUMMARY OF LAW	Specifically lists the types of providers eligible to provide telehealth services, including physicians, nurse practitioners, psychiatric nurse practitioners, physician assistants, certified nurse midwives, and clinical pharmacist practitioners.	Does not limit eligibility for Medicaid service reimbursement by provider type.	Does not limit eligibility for Medicaid service reimbursement by provider type.
LOCATION OF LAW	Clinical Coverage Policy No: 1H. Telehealth, Virtual Communications and Remote Patient Monitoring. NC Medicaid. ²⁷	Chapter 1: Telehealth. <i>MaineCare Benefits Manual</i> . State of Maine Department of Health and Human Services. ²⁸	Chapter 10: Individual Practitioner Services. <i>Fee-For-Service Provider Billing Manual</i> . Arizona Healthcare Cost Containment System. ²⁹

There are also variations across state laws in the types of telehealth services eligible for reimbursement under state Medicaid programs.²⁵ Some state laws are structured to allow for reimbursement of telehealth when those services are comparable to in-person services, without enumerating certain types of services. Other states' laws take a different approach, outlining lists of services that may or may not be provided by telehealth (see Table 3).

Table 3. Examples of state laws regulating telehealth services eligible for Medicaid reimbursement, as of June 2026.

	MINNESOTA	ARIZONA	NORTH CAROLINA
SUMMARY OF LAW	Covers telehealth services in the same manner as if the service or consultation was delivered through in-person contact.	Covers behavioral health telehealth services, including but not limited to diagnostic consultation and evaluation, psychotropic medication adjustment and monitoring, individual and family counseling, and case management.	Covers telehealth delivery of select outpatient behavioral health services.
LOCATION OF LAW	Minn. Stat. § 256B.0625, subd. 3b(a), (d)	Chapter 10: Individual Practitioner Services. <i>Fee-For-Service Provider Billing Manual</i> . Arizona Healthcare Cost Containment System. ²⁹	Medicaid Clinical Coverage Policy No: 8C. <i>Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers</i> . NC Medicaid at § 3.1.1. ³⁰

State laws also vary on whether telehealth services require audio-visual capabilities or if audio-only interactions may be reimbursable as telehealth services. As of September 2025, 46 states and DC allow for audio-only telehealth services,²⁵ with at least seven of these jurisdictions adding audio-only coverage in 2023.²⁴ Policy approaches to audio-only services reimbursement fall on a spectrum, with some states prohibiting audio-only services, others allowing audio-only services for specific types of services, and still others allowing audio-only services only when video capabilities are not reasonably available (see Table 4).

Table 4. Examples of state laws regulating Medicaid reimbursement for audio-only telehealth services, as of June 2026.

	ARIZONA	GEORGIA	VERMONT
SUMMARY OF LAW	Requires Medicaid coverage of "audio-only" services if telemedicine is not reasonably available due to the member's functional status, the member's lack of technology, or telecommunications infrastructure limits, as determined by the provider.	Excludes audio-only communication from the definition of telehealth but permits the use of audio-only service delivery for certain behavioral health services.	Includes a comprehensive list of audio-only codes approved for telehealth services such as, behavioral health and case management.
LOCATION OF LAW	Chapter 300: Services with Special Circumstances. <i>AHCCCS Medical Policy Manual</i> . Arizona Health Care Cost Containment System at § III.E. ³¹	Ga. Comp. R. & Regs. R. 135-11-.01 Telehealth Guidance. Georgia Department of Community Health, Division of Medicaid. ³² Georgia Department of Behavioral Health & Developmental Disabilities, Provider Manual for Community Behavioral Health Providers, 2027. ³³	Audio Only Telehealth Services. Department of Vermont Health Access. ³⁴

Telehealth Pharmacologic Treatment for ADHD and TS Services

The ADHD pharmacologic treatment with the strongest evidence to reduce ADHD symptoms involves prescription of stimulant medications,³⁵ which are classified as Schedule II controlled substances. Health care professionals must comply with both federal and state laws in prescribing medication. Federal law generally requires an in-person appointment between patient and prescriber before a Schedule II controlled substance may be obtained; however, this federal requirement was waived during the COVID-19 pandemic, at least through December 2026.^{36,37} State laws often require a patient-provider relationship to be formed before prescription of a Schedule II controlled substance is permitted; however, state laws vary in whether a patient-provider relationship may be adequately formed solely through telehealth services (see Table 5).³⁶

Table 5. Examples of state laws regulating requirements for prescribing Schedule II controlled substances via telehealth, as of June 2026.

	ALABAMA	ARIZONA	MONTANA
SUMMARY OF LAW	Requires at least one in-person encounter with the patient within the preceding 12 months.	Allows for prescription only after an in-person or audio-visual exam to the extent allowed by federal and state law.	Allows for prescription if the standard of care does not require an in-person encounter.
LOCATION OF LAW	Ala. Code § 34-24-704	Ariz. Code § 36-3602(E)	Mont. Admin. R. § 24.156.813(3) (c)

Regulations for different types of providers who may prescribe Schedule II controlled substances also vary by state, e.g., for advanced practice nurses and certified registered nurse anesthetists.^{38,39}

Private Insurance Coverage of ADHD and TS Telehealth Services

Approximately 43 states and DC required private payer insurance companies to provide coverage for health services whether the services are provided in person or via telehealth ("service parity")⁴⁰ as of April 2024. Laws in 24 states require private payer insurance companies provide the same payment rate, regardless of whether services are provided in-person or via telehealth ("payment parity") as of September 2025.⁴¹ Laws in 31 states and DC require cost-sharing, including copayments, coinsurance, or deductibles, to be comparable between telehealth and in-person services as of April 2024.⁴⁰

State Licensure

ADHD telehealth diagnosis and treatment may be provided by a variety of types of health professionals. The most common types of health professionals providing ADHD telehealth services to children ages

3 – 17 years old include psychiatrists, pediatricians/family practice physicians, nurse practitioners or psychiatric nurses, psychologists, and neurologists.¹⁹ Diagnosis and treatment of TS often involves a multidisciplinary team including neurologists, psychiatrists, and psychologists.⁴²

Health professional licensure is generally governed by the state. State laws generally require that a health professional be licensed by the state in which medical care is provided, typically defined as the location of the patient receiving medical care.⁴³ State laws vary in whether they streamline medical professional licensing across state borders through interstate compacts that recognize licenses across state lines, and for which types of health care providers. The following provides some of the interstate compacts designed to streamline interstate medical licensure:

- Forty-two states and DC have adopted the Federation of State Medical Board (FSMB)'s Interstate Medical Licensure Compact, which facilitates licensure for psychiatrists, pediatricians, and family practice physicians.⁴¹
- Forty-four states and DC have enacted the Psychology Interjurisdictional Compact (PSYPACT),^{41,44,45} which facilitates a centralized authority for psychologist licensure across participating states.⁴⁶ The first of these laws were effective July 1, 2020, in 12 states, with additional state laws becoming effective since.⁴⁵
- Four states (DE, ND, SD, UT) have adopted the Advanced Practice Nursing Compact,⁴⁷ which will allow Advanced Practice Registered Nurses, including nurse practitioners and psychiatric nurses, to care for patients across state lines both in person and virtually through a multistate license if enacted in at least seven jurisdictions.⁴⁸ Until seven jurisdictions adopt this Compact, it is not yet effective in any jurisdiction.

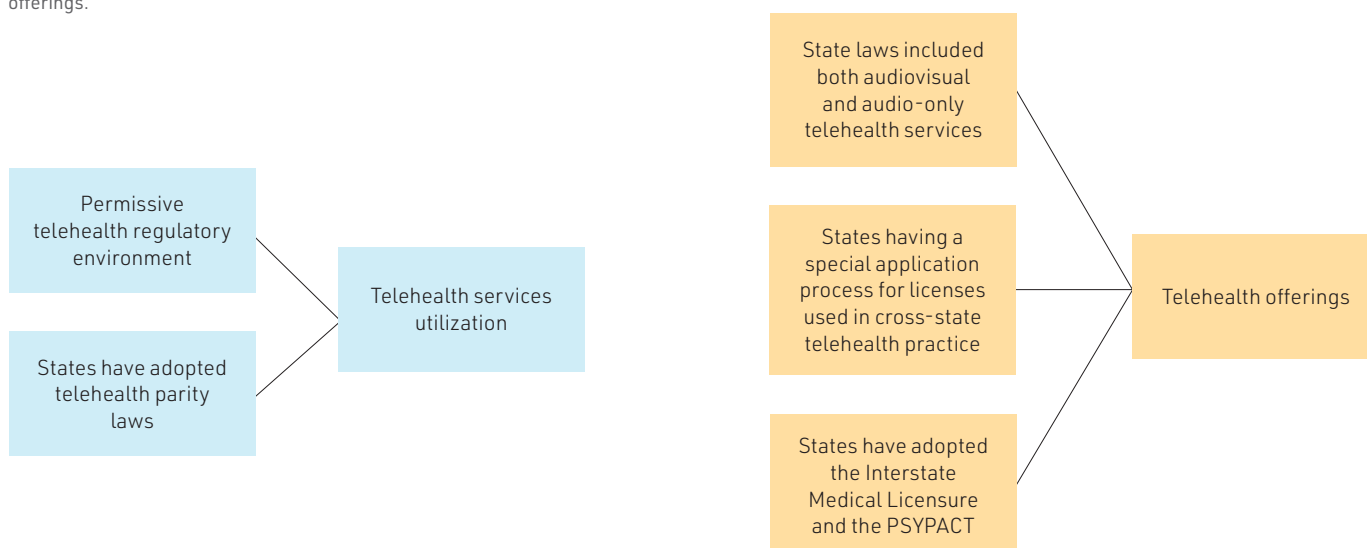
As an alternative route to telehealth practice across state lines, 18 states have established telehealth registries or limited telehealth licensure processes through which health care professionals with out-of-state licenses may be permitted to provide telehealth services to patients in that state.⁴¹

Rapid Assessment of Evidence

Evidence of Effects of Laws

No studies have examined the effects of state telehealth laws on ADHD or TS outcomes, for either adults or children. A small number of studies have examined the effects of state laws regarding telehealth services reimbursement and provider licensure on providers' offering or patient utilization of telehealth services, without focusing on children or examining the subsequent link to health outcomes. The existing

Figure 1. Existing evidence of relationships between telehealth or healthcare professional licensing regulations and telehealth services utilization or offerings.



evidence suggests that telehealth services are utilized more often in states with higher grades (i.e., A or B) from the American Telemedicine Association on their regulations of the provision of telemental health by licensed psychologists⁴⁹ and states that adopted telehealth parity laws.⁴⁹⁻⁵¹ Additional evidence suggests that telehealth offerings increased at a higher rate in states where telehealth parity laws included both audiovisual and audio-only telehealth services than in states where telehealth parity laws did not apply to audio-only telehealth services.⁵²

Studies related to state medical provider licensure laws have focused on the link between such laws and the number of health care facilities that offer telehealth services. Facilities located in states with a special application process for licenses used in cross-state telehealth practice⁵³ and those in states that have adopted the Interstate Medical Licensure Compact and the PSYPACT between April 2019 – September 2022⁵⁴ were more likely to offer telehealth services.

Evidence of Telehealth Interventions for ADHD or TS

Increased access to telehealth interventions for ADHD or TS could increase positive outcomes across a larger number of patients, if telehealth interventions are effective. Telehealth intervention can be an effective mode of ADHD and TS diagnosis, behavior therapy,^{42,55} and pharmacological therapy,^{42,56} with evidence suggesting certain online or telehealth interventions:

- were more effective in improving attention scores and social function of adults and children with ADHD, than when a patient remained on a waiting list without the intervention;⁵⁶
- resulted in significantly improved post-intervention behavior for children with ADHD whose parents participated in the Group Triple P Positive Parenting Program⁵⁷ and similarly for participants of a different behavioral parent training program when compared with a waitlist group of children with ADHD;⁵⁸
- resulted in child behavioral improvements for children with ADHD comparable to in-person groups;^{59,60}
- demonstrated improved inattention symptoms and organization, time management, and planning problems as well as improved emotional dysregulation and adolescent communication and reduced family conflict⁷ at post-treatment as compared to baseline—both at similar rates to those reported in face-to-face trials of the same treatment models in adolescents with ADHD;⁶¹ and,
- demonstrated reductions in tic severity at a similar rate to face-to-face delivery of CBIT in children with tic disorders.⁶²

For pharmacological treatment, a telepsychiatry model in which a psychiatrist provided medication prescription services via telehealth for several months, in combination with caregiver behavior training, demonstrated significant reduction in ADHD symptoms⁶³ and improvements in inattention, hyperactivity, and combined ADHD and oppositional defiant disorder (ODD)⁶⁴ compared to intervention of telepsychiatry consultation with a primary care physician. Stimulant initiation via telehealth also increased the likelihood of a follow-up visit after initiation of stimulant prescription, as compared to in-person initiation.⁶⁵ Some evidence has also demonstrated benefits of telemedicine therapies for TS, although authors highlighted a need for longer term research.^{42,55,66}

Quality Care Limitations

The potential benefits of expanded access to telehealth ADHD or TS diagnosis and treatment for children also come with risks.⁶⁷⁻⁶⁹ Since the implementation of COVID-19 policies that waive in-person appointment requirements for the prescription of Schedule II controlled substances, there has been an increase in the number of ADHD medication prescriptions,⁷⁰ specifically among adult patients rather than children.⁶⁵ Based on this increase in ADHD medication prescriptions, including an increase in telepsychiatry prescribing, experts have expressed concern on balancing access to effective treatments

and public health safety.⁷⁰ There have been instances of health care fraud through distribution of ADHD medications to persons with no medical need for the controlled substance.⁷¹ Questions remain whether telehealth results in accurate diagnosis given potential limits to patient-practitioner rapport, technological limitations, and patient malingering — although this has not been documented in any study.⁷⁰

Research Agenda

As the evidence base on the effectiveness of telehealth interventions for ADHD or TS continues to develop, evaluation of state laws and their impact on the offering, utilization, and outcomes associated with telehealth interventions for ADHD or TS becomes increasingly important. Further research could examine how telehealth regulations influence patient outcomes, access to care, as well as patient and community safety to ensure policy decisions are informed by reliable evidence.⁷²

To conduct high quality research examining these links, quality legal data is a critical first step. Existing research often relies on legal data that lacks quality control measures and relies on cross-sectional legal data in longitudinal studies.⁵⁰⁻⁵² Policymakers can benefit from increased access to emerging research about the efficacy of telehealth treatment as well as the barriers and benefits telehealth laws may place on children with ADHD or TS and their caregivers.

Policy Options for Further Exploration

With evidence emerging about the effectiveness of certain telehealth interventions for the treatment of children with ADHD or TS, telehealth services offer a path toward relieving some challenges patients face in attending the frequent contact with ADHD or TS treating professionals. Despite evidence of promising telehealth interventions for ADHD or TS, the body of evidence is still growing, and uncertainty remains about the effectiveness of certain types of telehealth interventions. In such an evolving environment, state laws regulating telehealth services can strike a balance between creating guardrails designed to ensure quality care while also facilitating access to ADHD or TS diagnosis and treatment when medically appropriate.

Based on the existing legal landscape and the existing body of evidence, this section provides a non-exhaustive set of policy considerations for policymakers, stakeholders, and researchers to consider within the context of their own jurisdiction and policy environment.

Patient-Focused Telehealth Accessibility

- **The expansion of locations patients are permitted to utilize telehealth services.** Although all 50 U.S. states and DC provide for Medicaid reimbursement for live video telehealth services, restrictions on the location at which patients may receive such services can limit patient access and thus utilization of such services. Since there is no specific evidence of potential harm associated with location, eliminating requirements that patients be located within specific facilities to receive telehealth services, and instead developing legal guidance allowing patients to access telehealth services from their homes or any other locations that the patient and provider find suitable, may advance telehealth accessibility when medically appropriate.
- **Cost-sharing parity between telehealth and in-person services.** Even when private health insurance companies cover telehealth services, patients can be deterred from utilizing such services if there may be high cost-sharing requirements, such as copayments, coinsurance, and deductibles. Policies that ensure cost-sharing parity between telehealth and in-person services may advance telehealth accessibility when medically appropriate.
- **Audio-only telehealth services when medically appropriate.** Increasing reliance on video-based telehealth for ADHD or TS diagnosis and treatment could exacerbate existing differences in access because certain communities, such as rural populations, are less likely to have access to high-speed internet needed for video-based telehealth services.^{73,74} Expansion of audio-only telehealth services

can be an avenue through which to address this inequitable access to resources; however, this can be balanced with consideration of privacy concerns, clinical guidelines, and evidence of clinical efficacy of audio-only telehealth services to ensure quality telehealth services. Future research can investigate use of other digital tools that require less bandwidth, such as secure chats and asynchronous messaging features, or digital monitoring to augment telehealth for ADHD and TS.⁷⁵⁻⁷⁷ Health advocates can also consider collaboration across sectors to support expansion of high-speed broadband access in rural and underserved areas.

Telehealth Feasibility for Health care Providers and Facilities

- **The expansion of the types of health care providers permitted to provide telehealth services.** Restrictions on the types of providers eligible for Medicaid reimbursement for telehealth services without clear connection to patient safety or efficacy may limit telehealth offerings. The expansion of the types of health care providers who may be reimbursed for telehealth services, so long as they are acting within their scope of practice, may encourage wider adoption of medically appropriate telehealth services for ADHD or TS.
- **Streamlined interstate health care professional licensure or telehealth registries.** Although many states have adopted interstate compacts designed to streamline licensure for certain health care professionals across multiple states, these compacts offer opportunities for a few types of health care providers rather than a comprehensive approach. Harmonizing interstate licensure and/or telehealth registries that expand access to a variety of types of health care providers, including advanced practice nurses, may increase the feasibility for health care providers to offer more interstate telehealth services.
- **Alignment of policies with current evidence and clinical judgement.** Telehealth services for ADHD and TS diagnosis, monitoring, and treatment vary widely, and the effectiveness of such services for any particular patient requires nuanced clinical judgement. Research into telehealth delivery of specific interventions is promising and evolving with clinical research. In such a dynamic environment, policies that provide coverage for telehealth services so long as they meet clinical efficacy standards can support health care providers in applying the most up-to-date clinical guidance without the lag inherent in enacting laws. Such policies may benefit from focusing on standards rather than developing lists of telehealth services that will be covered, as such lists lack the flexibility necessary for practice to shift with evolving evidence.

Conclusion

Telehealth services provide a promising path for increased ADHD or TS diagnosis and treatment in underserved communities and for children who face challenges with executive functioning, time, mobility, or transportation, especially considering the frequency of health care interaction necessary for treating these conditions. The potential benefits of increased reliance on telehealth for ADHD or TS diagnosis and treatment are balanced by unanswered questions about quality and effectiveness. Evidence on the effectiveness of ADHD or TS treatment delivered through telehealth also continues to develop and evolve. State laws take a variety of approaches to balancing competing priorities of in-person versus virtual health services that do not always reflect existing evidence. Existing evidence suggests avenues through which state laws may make telehealth interventions for ADHD or TS more accessible to pediatric patients and more feasible for health care providers to offer. Future research, which must begin with the creation of reliable legal data, could explore the connections between the nuanced legal restrictions on telehealth utilization and offerings and pediatric ADHD or TS outcomes.

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