TELEHEALTH

Telehealth prescribing of controlled substances: the Ryan Haight Act, the DEA extensions, and the evidence on virtual pain care

ABSTRACT

Six years after pandemic waivers first suspended the Ryan Haight Act's in-person examination requirement (21 U.S.C. § 829(e)), outpatient practices prescribing controlled substances by telemedicine still operate under a temporary extension. On December 31, 2025, the Drug Enforcement Administration and HHS issued a fourth temporary rule (90 FR 61301) extending COVID-19 prescribing flexibilities through December 31, 2026, while the agency's January 2025 Special Registrations proposed rule (90 FR 6541, which drew over 6,475 public comments) remains unfinalized in the Federal Register as of November 2026. Separate permanent rules cover six-month telemedicine buprenorphine initiation (90 FR 6504) and VA continuity of care, while Medicare telehealth coverage under 42 U.S.C. § 1395m(m) has cycled through repeated short-term congressional extensions. In the clinical literature, large Medicare (n = 175,778 across two cohorts) and Medicaid (n = 91,914) studies associate telehealth opioid use disorder care with higher treatment retention and lower or unchanged overdose odds, and a 2024 meta-analysis of 23 musculoskeletal studies reports high diagnostic concordance (κ = 0.80) — yet systematic reviews of spinal examinations and musculoskeletal telerehabilitation reveal thin evidence for surgical spine pathology and low review quality (69% critically low on AMSTAR 2). This review separates federal DEA authority, Medicare payment rules, Tennessee statutes (T.C.A. § 63-1-155), and the clinical evidence for virtual pain management.

Type Evidence and regulatory review **References** 25 **Reading time** 15 min **Last reviewed** November 2026

1 Three separate legal clocks governing one video visit

When a clinician in an outpatient pain clinic conducts a video visit and writes a Schedule II or III prescription, the encounter crosses three independent legal regimes that rarely move on the same calendar: federal Drug Enforcement Administration (DEA) controlled-substance prescribing authority under the Ryan Haight Act, Medicare and commercial payer telehealth coverage rules, and state medical-board and pain-clinic statutes where the patient is physically located.[1,2,3]

A practice that checks only one of the three routinely violates the other two. A prescription that is lawful under a DEA temporary rule can still be non-reimbursable under Medicare originating-site rules if Congress allows a statutory waiver to lapse; conversely, a commercial insurer that pays for video follow-ups cannot override a state

pain-clinic rule or a DEA state-registration requirement.[4,5]

Dec 31, 2026	0.67	κ = 0.80	69%
expiration of DEA's fourth temporary telemedicine extension (90 FR 61301)	adjusted odds ratio for medically treated overdose with OUD telehealth (Medicare)	pooled diagnostic concordance across 7 musculoskeletal telemedicine studies	of 35 musculoskeletal telehealth systematic reviews rated critically low quality

This paper reviews each regulatory layer as it stood in November 2026 alongside the peer-reviewed evidence on telemedicine prescribing and remote musculoskeletal examination. Like the library's companion reviews of PDMP mandates and EPCS rules, it distinguishes what the law permits from what the clinical literature has demonstrated.

2 The Ryan Haight Act and six years of temporary extensions

Congress enacted the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 to shut down rogue internet pharmacies that dispensed opioids on questionnaire-only orders. Its core prohibition, codified at 21 U.S.C. § 829(e), forbids dispensing any controlled substance by means of the internet without a valid prescription, defined as one issued for a legitimate medical purpose by a practitioner who has conducted at least one in-person medical evaluation of the patient.[1]

The statute included seven narrow "practice of telemedicine" exceptions under 21 U.S.C. § 802(54)(A)–(G) — covering patients located in DEA-registered hospitals or clinics, public health emergencies, VA facilities, Indian Health Service sites, and a statutory mandate for DEA to create a *special registration* for telemedicine.[6] For more than a decade after 2008, no special registration rule existed. When COVID-19 arrived in March 2020, DEA invoked the public health emergency exception under § 802(54)(D) to allow audio-video prescribing of Schedule II–V controlled substances without a prior in-person exam.[2]

From pandemic waiver to four temporary rules

When the federal COVID-19 public health emergency ended in May 2023, DEA and HHS found themselves between two opposing pressures: diversion concerns over purely virtual Schedule II stimulant and opioid clinics, and clinical disruption for patients who had established legitimate care remotely. The agencies responded with a sequence of temporary extensions and partial rulemakings summarized in Table 1.[2,7,8,9]

TABLE 1

Federal DEA/HHS controlled-substance telemedicine rulemaking timeline through November 2026.

Date	Federal Register action	Operative scope
Mar. 2020	DEA PHE exception letters under 21 U.S.C. § 802(54)(D)	Waived in-person exam for Schedule II–V audio-video prescribing during COVID-19 PHE[2]
Mar. 2023	Initial Telemedicine NPRM (88 FR 12875)	Proposed 30-day limits and in-person referral gates; drew tens of thousands of comments and was shelved[10]
May & Oct. 2023; Nov. 2024	First, Second and Third Temporary Extensions (89 FR 91253)	Extended full COVID-19 prescribing flexibilities sequentially through 31 December 2025[7]
17 Jan. 2025	Buprenorphine Final Rule (90 FR 6504) & VA Final Rule	Permitted an initial 6-month supply of Schedule III–V buprenorphine for OUD (including audio-only) after PDMP check; effective date delayed to 31 Dec. 2025 (90 FR 13410)[8,11]
17 Jan. 2025	Special Registrations NPRM (90 FR 6541)	Proposed three-tier special registration (Schedules III–V, limited Schedule II specialist, platform); received >6,475 comments; still unfinalized as of Nov. 2026[9,12]
31 Dec. 2025	Fourth Temporary Extension (90 FR 61301)	Extended full Schedule II–V telemedicine flexibilities through 31 December 2026 pending final special-registration rulemaking[2]

Two points in that timeline matter concretely for a pain practice. First, even under the Fourth Temporary Extension, four baseline conditions apply: the prescription must be issued for a legitimate medical purpose in the usual course of professional practice, via interactive audio-video telecommunications (except where buprenorphine audio-only rules apply), by a practitioner holding a DEA registration in the state where the patient is located (or exempt), and consistent with all other federal and state controlled-substance laws including EPCS and PDMP checks.[2,5] Second, an *already established* patient who has had at least one in-person medical evaluation by the prescribing practitioner satisfies § 829(e) outright; the Ryan Haight cliff affects patients who have *never* been examined in person by the prescriber (or a referring practitioner under a compliant referral framework), not established clinic patients conducting occasional video follow-ups.[1,2]

3 Medicare payment rules and Tennessee state law

DEA authority says whether a prescription is lawful; Section 1834(m) of the Social Security Act (42 U.S.C. § 1395m(m)) says whether Medicare will pay for the visit.[3] Before 2020, Medicare paid for non-behavioral telehealth only when the beneficiary sat inside a qualified rural originating site (such as a clinic or hospital), never at home.[3,13] Pandemic waivers removed geographic and originating-site restrictions, and Congress extended those waivers repeatedly through the Consolidated Appropriations Act of 2023, the American Relief Act of 2025, continuing resolutions in 2025, and appropriations bills into 2026 — briefly plunging practices over an October 2025 “telehealth cliff” and claims hold before retroactive legislative extensions restored coverage.[4,14]

By contrast, behavioral health and substance use disorder telehealth gained permanent statutory home-originating-site and audio-only coverage, subject to periodic in-person visit rules that Congress has separately deferred.[15] Non-behavioral specialty care, including routine chronic-pain follow-ups, still depends on statutory Medicare extensions for patients connecting from home in non-rural counties.[4,14]

Tennessee's telehealth statute and pain-clinic boundaries

State law governs the practice of medicine where the patient sits. In Tennessee, T.C.A. § 63-1-155 authorizes a Tennessee-licensed practitioner to establish a provider-patient relationship via telehealth through mutual consent and communication, holding telehealth encounters to the exact same standard of care as in-person visits.[16,17] Yet Tennessee couples that general permission with targeted controlled-substance and pain-clinic constraints. Tennessee Board of Medical Examiners rules and statutory pain-management clinic provisions regulate chronic-pain prescribing, require CSMD queries on the schedule reviewed in our PDMP paper, mandate EPCS for Schedules II–V under T.C.A. § 63-1-160, and restrict non-in-person buprenorphine prescribing to specified facility and employer arrangements.[16,18,19] A clinician in Cleveland, Tennessee seeing a patient just across the state line in Georgia also needs both a Georgia medical license and a Georgia DEA registration (21 C.F.R. § 1301.13).[5]

4 What clinical outcomes studies show on remote controlled-substance prescribing

The policy fear behind the Ryan Haight Act is straightforward: without an in-person exam, diversion, inappropriate prescribing and overdose could rise. The strongest real-world empirical evidence gathered since 2020 comes from opioid use disorder (OUD) cohorts rather than chronic non-cancer pain cohorts — an asymmetry buyers and regulators frequently blur.

Jones and colleagues examined two national Medicare fee-for-service cohorts of adults diagnosed with OUD: 105,240 beneficiaries pre-pandemic (September 2018–February 2020) and 70,538 during the pandemic (September 2019–February 2021).[20] OUD-related telehealth rose from 0.6% to 19.6% of beneficiaries. Within the pandemic cohort, receiving OUD-related telehealth was associated with higher odds of retention on medications for opioid use disorder (adjusted odds ratio [aOR], 1.27; 95% CI, 1.14–1.41) and *lower* odds of medically treated overdose (aOR, 0.67; 95% CI, 0.63–0.71), while overall cohort overdose rates remained virtually identical (18.5% vs. 18.4%; P = .65).[20]

A Medicaid cohort study by Hammerslag and colleagues covering 91,914 enrollees across Kentucky and Ohio in 2020 directly tested telemedicine *initiation* of transmucosal buprenorphine against traditional in-person initiation.[21] Telemedicine initiation was associated with higher odds of treatment retention and no increase in opioid-related nonfatal overdose.[21] That body of observational evidence is what underpinned DEA's January 2025 permanent Buprenorphine Final Rule.[8]

EVIDENCE BOUNDARY: OUD BUPRENORPHINE IS NOT SCHEDULE II CHRONIC PAIN

Both Jones et al. and Hammerslag et al. are observational cohorts of patients treated for opioid use disorder, mostly with partial-agonist buprenorphine.[20,21] Neither study was randomized, residual confounding (patients able to access video telehealth differ in stability and broadband access) cannot be excluded, and neither study tests telemedicine initiation of full-agonist Schedule II opioids for chronic non-cancer pain. Extrapolating OUD retention data to justify virtual-only initiation of Schedule II analgesics goes beyond what the published evidence supports.

5 The virtual musculoskeletal and spine exam: concordance and blind spots

In a pain practice, the clinical question is rarely only whether a refill can be signed remotely; it is whether a clinician can safely evaluate new or worsening radiculopathy, motor weakness, myelopathy or post-procedure complications over video. Three systematic syntheses published between 2021 and 2024 clarify what a remote physical exam can and cannot reliably measure.

First, in a 2024 systematic review and meta-analysis in the *Journal of Medical Internet Research*, Vincent and colleagues appraised 23 diagnostic and management concordance studies covering 1,493 adults with musculoskeletal disorders.[22] Across seven studies pooling Cohen's kappa (353 patients), diagnostic agreement between remote and in-person initial assessments reached $\kappa = 0.80$ (95% CI, 0.72–0.89; high GRADE certainty), with prevalence- and bias-adjusted kappa of 0.83 (6 studies, 306 patients) and pooled treatment-plan Gwet AC1 of 0.90 (2 studies, 142 patients).[22]

Second, narrowing from general musculoskeletal complaints to the spine changes the picture sharply. Piche and colleagues screened 2,321 records for a systematic review of virtual spine physical examinations in *Global Spine Journal* and found only three eligible studies totaling 88 patients.[23] While portions of a low-back exam showed acceptable agreement and over 80% patient satisfaction, the authors concluded there was a "significant void in the literature" regarding reliability for specific surgical spine pathology.[23] Motor-strength grading against resistance, deep tendon reflexes, subtle sensory dermatomal mapping and Hoffman or Babinski signs cannot be directly elicited without a hands-on examiner or an in-room clinical presenter.[22,23]

Third, Bargeri and colleagues conducted a 2024 umbrella review of 35 systematic reviews of randomized trials evaluating telemedicine for musculoskeletal disorders.[24] Across 60 meta-analyses, telemedicine produced noninferior or superior patient-reported outcome measures in 57, and lower direct costs across reviews. Yet

AMSTAR 2 quality appraisal rated 24 of the 35 systematic reviews (69%) as *critically low quality*, and objective physical-function endpoints were scarce compared with self-reported questionnaires.[24]

TABLE 2

Summary of peer-reviewed clinical evidence relevant to telehealth controlled-substance prescribing and pain evaluation.

Study	Design and population	Key outcome	Main limitation
Jones et al., 2022[20]	Medicare FFS longitudinal cohorts (105,240 pre; 70,538 pandemic, OUD)	MOUD retention aOR 1.27; medically treated overdose aOR 0.67	Observational; OUD population, not chronic pain
Hammerslag et al., 2023[21]	Medicaid cohort, 91,914 enrollees (KY & OH, buprenorphine)	Higher retention with telehealth initiation; no change in nonfatal overdose	Two states; 2020 pandemic period; nonrandomized
Vincent et al., 2024[22]	Meta-analysis, 23 MSK concordance studies (N = 1,493)	Pooled diagnostic κ = 0.80 (95% CI, 0.72–0.89); care plan AC1 = 0.90	Few red-flag accuracy trials; heterogeneous settings
Piche et al., 2021[23]	Systematic review of virtual spine exams (3 studies, N = 88)	Acceptable low-back agreement; >80% satisfaction	Tiny sample; no validation for surgical spine pathology
Bargeri et al., 2024[24]	Umbrella review of 35 MSK telemedicine SRs	Noninferior PROMs in 57/60 meta-analyses; lower costs	69% of included reviews rated critically low on AMSTAR 2

6 What the medical record has to capture on a video visit

Because telehealth prescribing sits at the intersection of DEA diversion audits, Medicare place-of-service edits and state board standard-of-care reviews, the clinical record for a video visit carries concrete structural requirements beyond a standard office note:[2,16,25]

- **Patient physical location at the time of service.** Confirming the patient's state and address establishes both state licensure jurisdiction and DEA state-registration validity, and enables emergency dispatch if an acute crisis occurs.[5,16]
- **Modality, consent and participants.** Record whether the encounter used synchronous audio-video or audio-only, patient consent to telehealth, clinician distant-site location, and any caregiver or in-room clinical presenter assisting with maneuvers.[2,16]
- **Prior in-person evaluation anchor.** For patients receiving Schedule II–V medications, surface the date of the last in-person physical evaluation directly in the chart so a prescriber knows immediately whether the visit rests on an established in-person relationship under § 829(e) or on a temporary DEA waiver.[1,2]
- **Explicit examination boundaries and escalation triggers.** Document which inspection and functional movements were observed visually (gait, seated transfer, active range of motion) and what could *not* be tested remotely (reflexes, resisted myotomes, palpation), paired with clear red-flag criteria that convert the visit to an in-person exam or emergency referral.[22,23]

- **Unchanged controlled-substance safeguards.** A video visit does not relax PDMP checks, urine drug testing schedules or Medicare LCD baseline documentation; those obligations remain identical to an in-person visit, as detailed in the library's reviews of urine drug testing and interventional spine LCDs.[19]

7 Preparing for January 2027 without betting on a waiver

As of November 2026, practices face a familiar year-end deadline: the Fourth Temporary Extension expires on December 31, 2026 unless DEA publishes either a final Special Registrations rule or a fifth temporary extension before then.[2,12] Industry commentary in late 2026 noted that DEA had advanced a final special-registration draft toward review, yet nothing had been published in the Federal Register.[12]

For an independent pain practice, the resilient operational posture is hybrid rather than virtual-only: conduct initial evaluations, new neurological deficit workups, periodic in-person physical examinations and urine specimen collections in the clinic, and reserve synchronous video visits for established-patient follow-ups, medication-response checks, imaging reviews and access continuity for rural or mobility-limited patients. That workflow satisfies the statutory baseline of 21 U.S.C. § 829(e) regardless of what DEA publishes on December 31, aligns with the clinical limits of the virtual spine exam, and keeps controlled-substance prescribing defensible under both federal and Tennessee law.

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