



State Medical Board of Ohio

**AD HOC TELEHEALTH COMMITTEE MEETING**

**July 23, 2020**

via live-streamed video conference

<b>Members:</b> Jonathan Feibel, M.D., Chair Michael Schottenstein, M.D. Mark Bechtel, M.D. Michael Gonidakis, Esq. Amol Soin, M.D.	<b>Staff:</b> Stephanie Loucka, Executive Director Kimberly Anderson, Chief Legal Counsel Nathan Smith, Senior Legal and Policy Counsel Jill Reardon, Director of External Affairs Tessie Pollock, Chief Communications Officer
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The meeting was called to order at 7:00 p.m.

Ms. Loucka stated that this *ad hoc* committee was formed at the last Board meeting because the Board recognizes the value of telehealth and how valuable a tool it has been during the COVID-19 pandemic. The Committee was formed to help the Board in its role in shaping what telehealth will look like moving forward and the standard of care that should apply.

Dr. Schottenstein appointed Mr. Gonidakis to the committee. Dr. Feibel was announced as the chair of the committee.

### **Draft Legislative Amendments Discussion**

Ms. Loucka stated that an amendment to House Bill 679, the telehealth bill, has been drafted for the Committee's review. Ms. Loucka asked for the Committee's guidance on possible changes to the draft amendment before it is presented to legislators for their consideration. Mr. Smith has provided a memo outlining questions that legislators may be expected to ask about the proposed amendment.

Mr. Smith stated that the draft amendment is loosely based on some teledentistry provisions that were inserted into House Bill 679 just before it passed the House. The draft also incorporates some aspects of the Board's 2012 telemedicine position statement and the Federation of State Medical Boards (FSMB) telemedicine policy.

### **Initial and Annual Visits**

Mr. Smith stated that the initial version of House Bill 679 required a patient's initial visit to a physician to be in-person, with additional in-person visits occurring at least annually thereafter. The physician could waive this requirement by determining that the situation is critical, and an in-person visit is not practical. The bill has since been amended to only require that the appropriate standard of care be satisfied. Mr. Smith stated that this leads to the obvious question of what the appropriate standard of care is.

Dr. Feibel expressed concern that this version of this requirement gives a great deal of leeway to the professional and would be very difficult for the Board to enforce. Dr. Feibel believed that most practitioners would not know the standard of care for such situations and the Board would have to establish it through the rule-making process, which would be very arbitrary. Dr. Feibel felt that for all specialties, except for a few, like psychiatry, it is important to develop the physician/patient relationship in person. Dr. Feibel opined that in the absence of a pandemic or other extraordinary circumstance, a patient should be seen in person on the initial visit and at least annually thereafter.

Dr. Schottenstein shared the board has two options: as a default, the board could support the expansion of telehealth with guardrails or support the restriction of telehealth with certain expansions. He suggested the board would be right in supporting the expansion and gave examples. The board can support the increased access to care with the understanding certain specialties or appointments when telemedicine would not be appropriate.

Dr. Soin shared he agrees with supporting the expansion and that the initial visit should include video. The DEA will have rules about requiring physical exams prior to filling prescriptions.

Dr. Bechtel stated an in-person visit is superior to video but there could be situations in which it would be a good option. However telephonic-only would not be adequate. He gave an example.

Dr. Schottenstein suggested dermatology may be a specialty in which telehealth visits works. He also stated by allowing telehealth, the board is not prohibiting in-person visits. It increases the flexibility.

Dr. Bechtel commented that there is a provision in the law giving a doctor permission to decline a telehealth appointment.

Dr. Feibel expressed concern that telehealth could be abused by physicians and be used as a financial opportunity.

Mr. Gonidakis agreed. He shared that in the past 10 years the board had an aversion to telehealth. He suggested looking past the current COVID-19 emergency to make the decision.

Dr. Schottenstein stated physicians still have a fiduciary duty and responsibility to standard of care. He believed guardrails could be put in place.

Ms. Anderson interjected that the rule for prescribing to patients not seen was amended a few years ago. A physician must do an evaluation, but they can do it in a method that is appropriate for the patient in the condition that they are being seen. That is generally being interpreted to include telemedicine, cross coverage, and other scenarios. It is not a true telehealth rule.

Dr. Feibel asked if under law, a physician could see a patient 20 times via telehealth in a year period, never having met in person. He commented that it is not the standard of care.

The committee discussed.

Ms. Anderson shared the current rule does require an in-person visit, but there are exceptions to do an evaluation remotely depending on the circumstance. It only applies to the initial visit for prescribing. Mandating an initial visit in all circumstances would require a rule change. If the change is in a statute, the statute would control the rule.

Dr. Soin, Dr. Schottenstein, and Dr. Bechtel were in favor of allowing the initial visit to take place via telehealth provided minimal standard of care were maintained and proper guardrails are put in place.

Mr. Gonidakis and Dr. Feibel were in favor of the initial visit taking place in-person.

The committee agreed to move forward with the initial visit taking place in-person barring extenuating circumstances that would better fit telehealth services.

### **Standard of Care**

Mr. Smith posed the question if the standard of care should be the same for in-person vs. telehealth visits. Part of the legislation discusses having a different standard for civil liability.

Dr. Feibel stated the board should hold licensees to the same standard of care.

Dr. Schottenstein suggested the language was included as a safeguard for doctors wanting to comfortably practice not having to worry about the fact, they could be liable just on the basis of performing telehealth services.

Mr. Smith stated the draft has a provision regarding civil liability, but the amendment in bold on page 5 under 2A, states “services delivered by health care professionals licensed by the board under telehealth shall be consistent with standard of care for in person services.” The board needs to think about the standard of care and civil liability when deciding.

Dr. Schottenstein stated the amendment language is contradictory to the statute.

Mr. Smith stated he based the amendment language from the FSMB model language and the 2012 position statement language. The board must feel comfortable deciding if the position should be the same as 2012.

Dr. Feibel shared he thought there should be language that telehealth used at time of the governor’s declaration of emergency should be immune from liability for using telehealth in lieu of in-person visits.

Mr. Smith stated there is legislation in the works right now regarding civil immunity for any health care services delivered during the pandemic – a separate emergency law governing the situation. He recollected there were aspects of the legislation that needed to be worked out in conference committee, but the law would be retroactive from the date the emergency was declared until the end of the pandemic.

Dr. Feibel stated he thinks that the language regarding care provided during the emergency should be included in this bill, because it changes who is eligible for telehealth during an emergency, if the civil immunity is removed from the bill. He also agreed during a pandemic, any type of initial visit is acceptable to protect the public. During a pandemic, a live visit would be an exception rather than the rule. Vice versa for a non-emergency time.

Mr. Smith stated with the civil immunity bill, people will be covered for the pandemic. He admitted there has not been a situation like this and suggested the board was relatively safe with the present legislation.

Dr. Soin agreed with Dr. Feibel that physicians should be held to the same standard.

Dr. Schottenstein asked with the contradictory amended language if the board should work with the legislature to change the language they have already proposed.

Mr. Smith reminded the committee civil liability language is only proposed language, not law. The board could amend the proposal to make it consistent: the standard of care for in-person visits equal to the standard of care for telehealth visits.

Ms. Loucka stated that the board had not yet tried to harmonize the rest of the bill around that new language. Once the bill is solidified, the board can take that step.

Mr. Smith stated if the committee chose the standard of care being the same, legal would have to revise some other parts and bring it back for review.

**Dr. Feibel moved to hold licensees to the same standard of care whether it is a telehealth or non-telehealth visit, except in extenuating circumstances.**

**Dr. Bechtel seconded the motion.**

Dr. Schottenstein agreed.

**All in favor. The motion carried.**

#### **Rule vs. Statute**

Ms. Loucka posed the question if the standard of care requirements should come through rule or statute.

Dr. Soin and Mr. Gonidakis were in favor of a rule, stating that it is easier to change with new information.

Dr. Feibel asked if rule changes are taking a year to complete, what happens if statute goes into effect during that year.

Ms. Anderson confirms it takes approximately a year to get a rule through.

Dr. Schottenstein asked if there is an advantage to having it in statute.

Ms. Loucka stated it is more advantageous to have flexibility of rulemaking, particularly in situations like pandemics. Even if normal process is a year, there is an ability for emergency rules. During this pandemic there were circumstances in the statutes in which board staff thought it could be more nimble if provisions were in rule instead. However, there will be a gap before the rules will become live.

Dr. Soin pointed out that laws may take a year or longer to pass as well and reiterated his being in favor of a rule.

Dr. Schottenstein expressed curiosity why the Board of Dentistry chose a law instead of rule.

Mr. Smith stated in the dentistry telehealth amendment, there are a few requirements for dentists to have to have either written or electronic form and they saved some rule making power. The main thrust of their regulating was giving all the requirements that an individual dentist would have to have in a written protocol, which does not give the same flexibility that rule-making gives. There may be a disadvantage in the first six or twelve months, but thereafter there is more freedom to adapt to changing circumstances. Rules are also reviewed at least every five years, to adapt.

Mr. Smith stated there would be at least 90 days.

Mr. Smith responded to Dr. Soin's question regarding how the board's existing rules would be incorporated into any telehealth statute. He referred to the draft of the standard language, under E2A, services delivered by health care professionals licensed by the medical board shall be consistent with the standard of care, and then under B, comply with the requirements of chapter 4731 of the Revised Code and the rules of the medical board. 2B ties it into board requirements and rules. Considering PA's and dietitians are also permitted to provide telehealth services by this legislation, the board may need to add a couple more numbers depending on what is in those chapters.

Ms. Loucka asked if the board can draft in such a way that allows the board's current rules to continue until new rules are adopted under this statute.

Mr. Smith confirmed.

Ms. Loucka continued; the board would have at least the net of the rules possessed today. She also reminded the committee some of the current telehealth requirements are suspended due to the pandemic. That may reduce the time between enactment and conflicting rules to a 4 or 5 month period.

Ms. Anderson stated when there is a conflict between statute and rule, you must follow the statute. On other things, the board can follow the rule which could provide guardrails.

Dr. Schottenstein asked if the board's language that would allow it to continue to using board rules would supersede that statute that contradicts the rule.

Ms. Anderson did not know.

Mr. Smith added this would not be passed as emergency legislation, and there would be at least 90 days. He offered another solution as delaying enactment, like the consolidation bill.

Dr. Feibel opined the legislature will try to enact this as quickly as possible. He suggested the board try to make a rule as quickly as possible and incorporate the current rule, to the extent that it does not violate statute.

Dr. Soin agreed.

Mr. Gonidakis excused himself from the meeting.

Ms. Loucka asked the committee what parts of health care professional patient interaction should be prescribed by statute or rule and if the committee shared the same thoughts for this question as the previous.

Mr. Smith asked if in the draft, the committee felt that D1 and its subsections covered the field of topics on which to make rules. He wanted to know if the committee felt there were areas that were too prescriptive or things missing.

Dr. Schottenstein asked to define the word *fully* in the phrase *methods to ensure that patients are fully informed*.

Mr. Smith stated he took the language from the dentistry telehealth amendment and proposed removing the word.

Dr. Soin and Dr. Schottenstein agreed.

Ms. Loucka asked how the board accounts for differences in specialties or professions when looking at standard of care requirements. She opined that legislators would ask what kinds of things the board will put in its rule.

Dr. Feibel expressed he thought it will be more specialty specific rather than MD or DO. He suggested it will take time to decide the level of specificity.

Ms. Anderson stated historically it has been the most difficult question and the board has generally landed on very broad language such as “appropriate for the condition” or “appropriate for the patient.” It also includes more universal aspects such as record keeping and making sure the patient is informed, etc. She suggested looking at other state rules. Many of the FAQ’s the board has on 4731-11-09, deal with specific practice situations that are outliers (psychiatry, colonoscopy, etc.)

Ms. Loucka shared the next question as how the board’s existing rules should be incorporated into the legislation, or if they should be kept as rule.

Dr. Soin is in favor of maintaining guardrails. He shared in absence of the board’s current rules, he would be uncomfortable with telemedicine in pain management considering what has happened in Ohio with excessive prescribing.

Dr. Schottenstein agreed and stated his previous comfort with expansion of telemedicine was in knowing that the board has guardrails in place for these specific areas of medicine.

Dr. Bechtel and Dr. Feibel agreed.

Ms. Anderson stated the board’s current rule only deals with the initial visit when there is prescribing. The rules under this statute would be broader and would deal with telemedicine if it was the second, fifth or twelfth visit. That has likely been a gap.

Ms. Loucka shared the last question as if the services should be allowed to be provided via asynchronous technology, which do not have both the audio and video. This would include delivery by telephone and email.

Dr. Soin stated he understands there are situations in which a patient may not have a smart phone or access to technology but there are separate rules, billing codes for Medicare for a telephone visit. He supports an audio/video synchronous interface. Doctors and patients can still email, and telephone exchanges as currently allowed.

Dr. Feibel agreed.

Mr. Smith stated in the emergency Medicaid rule on page 48 of the reference document, they defined telehealth. Definition: via synchronous, interactive real-time electronic communication comprising audio and video elements.

Dr. Schottenstein asked to clarify if now with CPT codes physicians may complete a phone consultation.

Dr. Soin confirmed. He hoped using a phone visit due to extenuating circumstance would be rare. Medicare has been clear on its guidance, even during the pandemic, that there must be a video interface to bill for codes similar to how it would be billed in the office. Without video, when a telephone is used, the physician can still bill for it and Medicare is paying during the pandemic, at a lower rate.

Dr. Feibel added it also means the physician has not seen the patient within seven days and will not see the patient again within the next day, to get paid for that code. If Ohio allows this, this might change that and allow those people to potentially bill at least bill private insurance. He is in favor of video and audio synchronous.

Dr. Schottenstein stated there are patients without good internet or technology or are averse to being on video. There is also an expense; maybe a patient can afford a phone but not a computer or laptop or iPad, etc. He suggested there could be language that allows for exception if extenuating circumstance can be documented.

Dr. Soin agreed with the understanding those extenuating circumstances can be specifically documented as a rationale.

Dr. Bechtel pointed out older populations (80 and 90-year-olds) do not have the proper technology. He cautioned the committee to be careful not to exclude access to older adults. He opposed using telephone visits for initial visit, but if the licensee has a relationship with an elderly patient with a medical question who cannot do a video visit because they lack a smartphone, an exception should be considered.

Dr. Schottenstein stated technology is not perfect, even on this meeting, video may freeze at times and phone may have to be used to finish the visit.

Dr. Soin suggested writing it to preserve the intention of an audio video interface, making a good faith attempt, and if that fails and there is extenuating circumstance, then a telephone may be considered.

Dr. Feibel referred to page 7 of the pdf, which says *a health care professional may negotiate with a health plan issuer to establish a reimbursement rate for fees associated with the administrative cost incurred in providing telehealth services as long as the patient is not responsible for any portion of the fee.* He stated it was dangerous to put in the statute because it will thing to put into statute because it will encourage telehealth. He asked if it was referencing something other than an office visit fee.

Dr. Feibel questioned the next line as well: *health care professional providing services shall obtain patient's consent once before billing for providing the services.*

Dr. Schottenstein also shared his concern with the language about needing verification of the patient by asking for name and password, or a personal ID number.

Mr. Smith stated he would have to get back to the committee with the answers. The focus of the initial draft and the meeting was to deal with the standard of care provisions. Board staff envisioned at least a couple of meetings of this committee. The billing and technology issues can be addressed at a future meeting.

Ms. Loucka stated that these questions can be researched for the next discussion. This language has already left the House and the board will be speaking with the Senate.

## **Adjourn**

**Dr. Bechtel moved to adjourn the meeting. Dr. Soin seconded the motion. All Committee members voted aye. The motion carried.**

The meeting adjourned at 8:20 p.m.

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