2019 SENATE HUMAN SERVICES

SB 2094

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2094
1/9/2019
Job # 30573

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez/Alicia Larsgaard

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact sections 43-17-44 and 43-17-45 of the North Dakota Century Code, relating to the practice of telemedicine; and to amend and reenact subsection 3 of section 26.1-14-02 and sections 43-17-01 and 43-17-02.3 of the North Dakota Century Code, relating to the definitions of the practice of medicine and telemedicine and the practice of medicine.

Minutes: Attachments: 1-7

Chairman Lee: Called the hearing to order on SB 2094.

(0.00-9:00) Bonnie Storbakken: Testified in support of SB 2094. See attachments 1-2.

Senator Anderson: In regards to the letter from the State Medical Board, it mirrors your law of which says you have to have that video that is comparable to the evaluation. What some people are telling us is that we are the only state that is adopting that policy. Do you have any numbers about what other states have done relative to that?

Bonnie Storbakken: I do not have the exact numbers of who is doing what. What I can tell you is that I think it's about 39 states that require a patient licensee relationship. How they all define hoe that can come about is different. That is why we look to the model. I can tell you that as far as the requirement of a parent licensee relationship, I think that is pretty broad. How they define that, I do not know. Minnesota, Montana, and South Dakota do not have any special previsions for telemedicine. They don't have any special language to define it. I have spoken with our counterparts and with their responses, we are not sure if that is better or worse. So, when we get a complaint, we have to try to fit it in under our current rule structure. Under what we have in rule, that is what we would have to do. We would have to find how we can do that and the disadvantage of that is that we are not able to provide clear direction to our licensees and when it comes time to review some of those complaints, it is extra work. We may not have the best tools and our board really believes that this bill has the tools that would help clear that up.

Senator Anderson: How do you anticipate that your board is going to govern that practice idea that you brought forward?

Bonnie Storbakken: Currently, when a complaint comes in and we see somebody who is a neurologist that has treated someone for internal stuff, it is far outside of where their training is and our board has the ability to say something. We have to look at it so see if it is negligence. We have looked at similar complaints with specialists who go outside of their specialty and bad results happen which leads to complaints coming to us. I think that was a reiteration of what we already do.

Senator Hogan: Do we have any idea what the volume of telemedicine is in North Dakota and how much is being practiced today?

Bonnie Storbakken: I don't have an answer for that. I think some others here might know more than me about that.

Senator Roers: I noticed there is some language where you switch from "licensee" to "practitioner". Was that an intentional move? Because I don't see "practitioner" being defined.

Bonnie Storbakken: I have had to redo the language.

Senator Roers: Do you feel that having them strictly within this section could limit the scope of who could do telemedicine or will those groups also need to define it in their section? I just worry that now we are going to create 5 times the code than maybe putting it in a larger section that could apply to a larger group.

Bonnie Storbakken: One of the major statements in opposition to this bill is the lack of broadness in the State of North Dakota. I have included materials in my testimony for you about that topic.

Chairman Lee: Enable us on what your further attachments are please.

Bonnie Storbakken: I have given you a current rule. The historical documents are the packets that were submitted to the administrative rules committee. After that, I have provided copies of other law such as the parody law for payment regarding telehealth, the medical marijuana law where it talks about the glorified patient provider relationship, and the model policy from the AMA and the FSMB. I have given you some recent emails that I have received as well.

Chairman Lee: Who would like to testify next for SB 2094?

(18:40-23:45) Brenda Miller, Member, Board of Medicine and Licensed Physician: Testified in support of SB 2094. See Attachment #3.

Senator Clemens: When you have a new patient before you go to something that is not visual, does that occur after the patient has told you that they are comfortable meeting with you? How long does that usually take?

Brenda Miller: I think it depends on the nature of the visit but patients usually pick me and I hope they would feel comfortable with my recommendations from people in the community.

To answer your question, I would say it is right away for the most part. If they didn't, they probably wouldn't be back.
(24:50) Chairman Lee: Part of the problem for a lot of patients is the specialty areas. Sometimes its 4-5 months before they can get in. Because they don't want to wait that long, they will try to figure out some other way to get it to someone. I am not saying it is a goof judgement call, medically. Every place has challenges recruiting and we all know it is challenging in the state of North Dakota, especially in rural areas. I think we have to make sure services available to the people are going to be appropriately guided in a good way so they are going to get good treatment.

Brenda Miller: We have the opportunity in our clinic to have video visits. They can call in from anywhere with any device. I realize some people don't have the technology but I think a lot of the specialty cases are important to have the video feed option. My son in interventional radiology. His patients come from all over the state and even Montana and for them to be able to follow up with him over video and have some nurse from where they are check their pulse, that would be invaluable to those patients. So those are some things that are falling under the telemedicine that go well within what we are discussing.

Chairman Lee: The importance to be able to follow up is so great, regardless of where they are at; especially with chronic disease.

Brenda Miller: I work for Sanford and I have been so blessed with such a supportive system. We have a chronic disease management team. After we have established that relationship either in person or over video.

Chairman Lee: The gadgets that are available to read blood sugar and able to monitor their own responses are incredible. That way people are able to monitor their own situations. I love the electronic communication options as well. If I have a question, I can just send it. I don't have to wait for someone to call.

Brenda Miller: It has made my life easier as well because it is easier for doctors to send and receive emails.

Chairman Lee: Who would like to testify in favor of this bill next?

(29:16-36:14) Darin Willardson: I have been practicing telemedicine for 4 years. I have seen over 7,000 patients. Most of them have been over the phone and telemedicine visits. There are a few things I would like to bring to your attention where the intent might be good but you might be limiting some of the aspects of what telehealth will be becoming in the future. I practice currently in MN but we are branching to different state and one that I would love to branch to is ND. One of the things I will bring up is when we practice hospital medicine, we would get calls from hospitals with 25 beds or less asking if they would come over to the hospital. We would go and we would jokingly call it "dozing for dollars". Unfortunately, they aren't very busy so we would go there and sleep for 12 hours. We said that there has got to be a better way to do this and for me to go cover a hospital and have only one admit, is not very efficient. We came up with the tele hospitalist model. What we do now is we have hospitalists that cover multiple hospitals at the same time. We make these carts and place them in many different hospitals which allows me to sit in one spot while covering 4-5 different

hospitals at one time. When a patient come in, they can see a person who practices in a higher bed number hospital and they do not have to be transferred out of their small town hospital to receive the proper care. This has been shown to be very valuable. The smaller hospitals love it and so do the patients. One of the things that I see in this bill that is going to be restrictive for that is if you go to page 4, we prescribe controlled substance I the inpatient setting. This does not carve out in patient setting so it someone come in and needs their gall bladder removed and it is 2 AM, the patient would probably like some pain medicine until the surgeon can get there at 6 AM. What I would like to ask of the members here is that if you could add on line 21 where it says you can't provide opioids, please add to the end of the sentence, "with the exception of a hospitalized individual or nursing home resident". In a controlled environment, like that, with the proper telehealth equipment, it would be just fine to use opioids in this case. I agree that it should be for outpatient. This bill is great but I still believe there are some things that would limit what we can do, unintentionally. This would be one of them. The other things are, when a patient comes to me, most patients prefer where they don't do a video especially if they are at work. They want to be private. The software I use clarifies the patient. They can't impersonate someone else. Once that happens, then when you get on the site, you have to go through a third party to verify that it is you by answering various questions. It would be difficult to craft bills like this because what you are going to want to do is limit providers that use any kind of email or anything to do this. But those of us who use a very safe and robust software to do this, should be allowed to. When I do a visit, they know exactly who they are visiting with and I know exactly who I am treating. If I give a prescription, it goes to the pharmacy where it is again verified. I think this intent of this bill is good but I think you are about to limit North Dakota to something that other states are not limiting.

Chairman Lee: That is why we meet every 2 years to update these things. Can you provide the remarks that you just made?

Darin Willardson: Absolutely.

Senator Hogan: Are there national standards that you have to comply with or is there an infrastructure with a primary way of providing the service? It is a new form of medicine, so do you have the national standards and the boards for it?

Darin Willardson: That is what we are addressing now. There are no national standards for this and that is what the scary part of all this is. Those that are practicing responsibly, are cringing when we see stuff that limits what we can do, not because we are doing something wrong, but because other people are doing something wrong. I think it would be better to write bills that say you have to have an accredited software that identifies the patient and the provider to each other instead of just saying, "you can't do that".

Chairman Lee: We want to prevent abuses that are happening out there.

Darin Willardson: That is why we have to be careful on how we craft this. Most of this bill is great but I think the inpatient side was sort of forgot about in the part where it is a very controlled environment and that is why I asked for that exception.

Senator Hogan: Who accredits your software and are there very many of them?

Darin Willardson: It is up to the individual people providing this software to make sure their software is robust. There are no national standards.

(39:40-41:17) Marnie Walth: See Attachment #4 for the Testimony in favor of SB 2094.

Senator Anderson: You don't see the video as a way to establish your relationship as a barrier that you can't overcome, do you?

Marnie Walth: We do not see that as a barrier. We support that requirement.

Senator Hogan: Do you have feedback for opioid prescription for inpatient telemedicine?

Marnie Walth: That is a good question and I would have to take it back to my office.

Chairman Lee: Next in favor of the bill please come up.

(42:00) Donna Thronson: Testified in support of SB 2094. See Attachment #5 for Testimony.

Senator Anderson: Already in North Dakota law, we have confrontation with another medical provider that can always be provided. You don't have to have an ND license. We can take a closer look at that and see.

(46:09-46:32) Melisaa Hauer: Testifies in support of SB 2094. See attachment #6 for testimony. We support the bill and we think it strikes the right balance between patient safety and using the technology that is coming along to help patient access, especially in rural areas.

Senator Roers: Where does the hospital stand on the opioid exception for inpatient and long term care?

Melissa Hauer: I do not know, but I will go back and check as well.

(47:22) Todd Savernak: Testified in favor of the bill. I practice both telemedicine and inpatient hospital medicine and similar to Dr. Willardson, I would like to speak that looking from a patient care standpoint, that limiting the opioids and inpatient care setting is very limiting and will result in less care. That is limiting the small hospitals that we are trying to support. I strongly support inpatient settings and want to make sure that that carve out is made. It is clearly a different setting.

Chairman Lee: Any further testimony in favor of the bill? Hearing none, are there any opposition testimonies to the bill? Hearing none, we will close the hearing on SB 2094.

Further testimony was emailed in support of an amendment to SB 2094 from Dr. Mary Ann Sens. See attachment #7.

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Minutes: Attachments 1-8

Madam Chair Lee: Opens the hearing for SB 2094 continuation for opposition testimony.

(1:47-9:52) John Ward, Attorney and Lobbyist representing Teladoc. Testifying in opposition to SB 2094. Testimony is as follows.

John Ward: I have the pleasure of introducing several individuals today. Donna Campbell who is an ER physician and a Senator from Texas. I also have the Vice President of Government Relations for Teladoc, Claudia Tucker, who is an individual that has decades of policy experience and can specifically address your policy questions. I'm not sure how familiar you all are with the background of how this has evolved since it originated at the administrative rules committee where this came originally as an administrative rule. That rule was adopted with a significant amendment that left the definition of Telemedicine and did not include several of the requirements that are listed in the statue that is before you. The statute that is before you are a good statute except that it requires a video visit at the initial establishment of the physician patient relationship. This is potentially the most restrictive statute that would be implemented across the nation. That requirement is really arbitrary; it has not been shown by medical data or combination of various methods of establishing the physician-patient relationship are utilized millions of times a year throughout the U.S. The physician discretion is important to protect. This bill will apply video as a component in every single circumstance. If you are to pass this statute what you are saying is that in every circumstance the video component is necessary to establish the physician-patient relationship.

(5:08) Madam Chair Lee: Are you saying that every time they are going to make a connection, because that is not out understanding. The initial contact with that Tele-provider.

John Ward: That is Correct.

(5:27) John Ward: (continues testimony) Every single time that you are initiating that physician-patient relationship the bill requires video. Now it is my understanding in reading the bill that after you have established the physician-patient relationship that you can utilize technology as the physician deems appropriate. We don't believe that is a meaningful distinction, that there shouldn't be this video component. What we have before you here in a proposed amendment it modifies Page 3, Line 23 and replaces the language of "A Video" with "An". There was an article that was published in the Bismarck Tribune, in which the Board of Medicine that in the states of Georgia, Alabama, Texas, and Arkansas that they have similar statutes in place. That is not accurate. The state of Arkansas has a similar statute that requires video as a component. However, it is my understanding that statute is being reconsidered by the state of Arkansas that we believe is defective. **(Please see Attachment #1 for Arkansas statute.)** As far as our neighboring states. The state of Minnesota has a very good and broad Telemedicine policy and allows for the doctor's physician to use technology as they deem appropriate and essentially what Minnesota has is standard of care language, it says that the Telemedicine encounter has needs to be conducted in accordance with the same standard of care as that of an inpatient visit. That's all we need, to some extent most of this is over legislation because when a physician is held to the same standard of care then both the board has the authority to oversee any kind of conduct that that physician would be held to that standard. Also we have the civil process in how the standard of care is applied in a given situation. Overall I think the biggest thing here is that we don't see the reason and based on my client's experience which involves over two and a half million visits in 2018 alone that the efficacy of interactive audio in which a treating physician has a medical record for the patient in front of them combined with the other technology that is available to them that they are practicing well within the standard of care. It should be clear to everybody as well that each situation is different. Obviously a physician is not going to exceed the standard of care that as far as the technology that's used and available to them. We think that North Dakota licensed physicians are good doctors and they are going to know what information is appropriate and necessary in treating a patient.

Senator Anderson: We had earlier some communication from the Federation of States Medical Board about that section that requires the face to face video, and I asked them how many states adopted that provision? He answered and said 17 states. **(Please see Attachment #2)** Obviously you disagree with that because you could only find one and they were reviewing there's. I'm not sure what I'm hearing from both sides here.

John Ward: I guess I haven't seen the communication that you've had and maybe one of these ladies can speak to that better but as far as the Federation of State Medical Boards goes I think there are certain recommendations and I think those do actually flow into the bill so there are a lot of sections that address this. What I'm specifically speaking to is the states that specifically prohibit interactive audio and there are two of those that specifically require the video component and those states are Arkansas and Delaware. As far as the other information I would not be able to speak of that.

Madam Chair Lee: I have a letter from the Federation of State Medical Board and so we have that information for the committee and they have supported this proposal and the other thing is the National Conference of State Legislature and the American Medical Association did a 50 state survey on this topic recently and there's more than one state that requires video. The ones that are listed here that would be comparable of what we are talking about.

Some of the examples that were given were Alabama, Arizona, Delaware, Georgia, Mississippi, and Missouri. Those are just examples of some of them but there are 17 that have something. I think that both of the two organizations have some credibility about this too. We may just have a difference of opinion on how the question is being asked as far as being real specific to something or in general but there are definitely with laws for the initial visit between a patient and a remote provider. **(Please see Attachment #3 for Federation of State Medical Boards letter referenced by Madam Chair Lee.)**

John Ward: Just so I'm clear specifically what we are talking about, is the video component as relates to the establishment of the physician-patient relationship and it's not any of the other standards that flow through that are actually in the statute. Teladoc is supportive of this statute with the exception of that initial video component. This is a letter from a North Dakota physician that speaks to opposition to the bill as written. **(Please see Attachment #4 for testimony of Mandy Sorlie, M.D. presented to the committee by John Ward.)**

Senator O. Larson: Your amendment that you proposed it just allows that initial video conference to take place if someone comes in and says I have a rash and they want to initially go yeah I'll take a look at it. They can choose either or it doesn't lock them into it.

John Ward: That's exactly correct. That's one of the things that has been conveyed to us and I can't recall it was Senator Anderson who still sat on the administrative rules committee at the time but we did have some physicians come and speak at that time and they spoke about how a photograph from your phone that has a better resolution is actually preferable to a video encounter because it is moving. For example, you're dealing with a rash you could take a better photo with your phone that a doctor has the opportunity to expand and take a look at as opposed to holding the phone to your rash while you are on a high speed video connection.

Madam Chair Lee: This is irrelevant except I can't imagine why anybody would primarily go to a Tele provider for a rash. The point that were made by those you didn't hear on Wednesday. A lot of what is important in that primary visit is more than just looking at, I don't even want to use rash as an example, by seeing the person the physician can see how they respond and their behavior. There is a great deal of other things learned by observation and that video aren't the same as a picture. If someone wants better resolution they can ask to get the picture as well but if it is an initial visit to seeing what other things are going on with that patient. That is part of what you didn't hear before that was important to the conversation.

John Ward: Unfortunately, I couldn't attend, but we did have an associate that attended so I got the chance to read a memo, and I would be more than happy to answer any questions about anything that would have been raised by the proponents of this bill at that hearing if there are any further questions.

(17:00-26:28) Doctor Donna Campbell, ER Physician and Texas State Senator. Testifying in opposition to SB 2094. (Please see Attachment #5 for testimony.)

(27:20-33:36) Claudia Tucker, Vice President of Government Affairs for Teladoc Health. Testifying in opposition to SB 2094. (Please see Attachment #6 For testimony.)

Senator Clemens: We all know there is a shortage of physicians and we want everyone to have healthcare. This bill has an excellent definition of telemedicine. However, in section four there is restrictive language. The required video for the first encounter. The second encounter is likely to be with a different doctor.

Senator Anderson: We are using the modern terminology of telemedicine here. What your suggesting is exactly the telephone where people could call up and answer some questions and the only difference is instead of keeping them in a paper file, now they are going to keep them electronically. What your suggesting is exactly what could have been done here for 100 years for people, am I wrong about that?

Claudia Tucker: You're absolutely correct and I think there is a misunderstanding about this audio. A lot of legislation at the very end will say telemedicine does not include audios, facsimile, texts or emails. We vehemently agree with that statement. Because what we are talking about is interactive audio where the physician either knows the patient or they have access to their medical records on file. We do not believe that someone should be able to call up a physician without any prior medical record on file and be able to talk to that physician. That's how the pinwheels got started in 2008 and that's not what we are talking about when we say telephone and active audio and so your exactly right.

Senator Anderson: I' m going to call a physician and they are going to take down my medical records. So it's the same as a phone call to a provider. I am guessing in your case the questions are not written down by a physician, they are written down by some allied helper, or professional and then the physician either calls me back or gets on the line when that person is done. So, explain to me when you say it's not just audio or fax questionnaire or whatever because it seems to me that is what you're suggesting what we do here.

Claudia Tucker: This is not a direct to consumer benefit which means that it is a benefit that is provided by an employer or a health plan. A health plan decides that they are going to offer this benefit.

Senator Roers: I am a nurse and I am coming from the provider side of this, and I think that what I'm hearing from my fellow senator is that your service maybe only from that perspective but the law is not written to be specifically that way. So if we take out that video component it does not guarantee that it is going to be interactive audio from some other person that is providing this service under this law. This is what I am hearing.

Claudia Tucker: I don't think that I understand what you're saying.

Senator Roers: So your particular service if I call in you already have my information because I have a relationship through my employer. Now, company Z maybe providing telemedicine and is not working under the same guises that you are, and may not have my information, so my concern is if we take away this safety piece of being able to see where is this patient developmentally, from the psychiatric perspective, are they having any symptoms from their antipsychotics those types, how do we insure that someone doesn't take this law and distort it to use it in a non-interactive audio way?

Claudia Tucker: Well I will tell you that the North Dakota Board of Medicine holds the license for every physician that practices here. So even though we got a physician that maybe in Montana and they've got a ND license, were they to do something untoward they could grab their license. You've got the laws in the books now that protect you from bad medicine.

Senator Roers: I am not saying untoward. I am saying you guys have that safeguard built in that you already have the medical records. What prevents someone who doesn't already have that piece of information to utilize this in the way that may not realize is incorrect, because they don't have their same system set up around it. That's my concern.

Claudia Tucker: You could add an amendment and I actually talked about this. You can add an amendment to your bill that says, prior to any interaction with a patient they must have access to the medical record. That is an easy amendment. I see you've gotten a lot of other states.

Senator Clemens: How many people do you estimate would be cut out of this bill if the video stayed? Is there a large number of people that would not have access to video?

Claudia Tucker: I would say you take away choice. If choice is important to you then you could just enfranchise folks. I know that ND is number 18, in broad band access, and I researched that myself, because you are ahead of the great state of Virginia which is where I am from. It's not a broad band issue, it's a sophistication issue or a senior issue. I know a lot of seniors who call up Teladoc they usually don't want to use their smartphone. If you believe in choice and believe that patient choice is important then you understand the reason for the amendment.

(Unknown Speaker): Would it be acceptable Madam chair I would just like to respond to Senator Roers question. So I believe there is actually language within the statute as it is written, that actually follows that section. It actually says that it cannot be audio only or cannot simply be a static questionnaire. So that is actually in there so I think the bill as drafted will eliminate those situations that video concern about there.

Madam Chair Lee: We had some amendments that were suggested last week and there was one about the fact that the video component would not be required if there was a referral or prior relationship with the referring physician. Which is different as well.

41:00-42:00 Jack McDonald, representing Americas Health Insurance Plans. Please see **Attachment #7** for testimony.

Jack McDonald: Basically our concerns are the same as being raised by the other witnesses tonight. The concern is about the requirement for the video examination.

Madam Chair Lee: Well we have had and I don't think it turfy, we have had support from the North Dakota Medical Association, and from the Board of Medicine here as well, who also of course are careful about good practice. You and I have benefitted from that I suspect. So I don't doubt the motivation of the people who are concerned about this, but I don't doubt the motivation of the people who think the bill has a merit also.

Senator Anderson: Can you get me a definition of an asynchronous store in forward technology? Maybe if we understood that better we would be able to understand.

Jack McDonald: replied he will email that to Sen. Anderson.

Senator Anderson: That's one of the question, that telemedicine is and one of the things in there is asynchronous store in forward technology. If we understood this better, we might be willing to go along with some of this suggested changes here. But I don't think that I understand it very well.

Senator Anderson: If the patient happens to have insurance and has the information on their system but we have to look out for everybody like grandma, grandpa on the farm and not have any insurance. Unless there is some verifiable way to see that those people are actually examined them, and found out whether they had a UTI or whatever they had, unless there is some verifiable way for the medical board to say this was good care or not care, we are assuming it wasn't good care.

Madam Chair Lee: We has also an amendment, actually 2, that were recommended by Doctor Maryanne Sands one of which was to lengthen the time period in one section from 24 hours to 7 days, and the other one.

Senator Roers: I think that one we thought was covered in another, the exemption was already covered in another section.

Madam Chair Lee: Then her proposed amendment in Sect. 2 was to include an intra-specialty clinic or consultation for diagnosis of a patient in this state provided that both specialists are trained in the same specialty and that specialist requesting the consultation has a physician license to practice medicine in the state. So there were a couple of thought from other people as well.

Dr. Gabriela Balf-Soran (45:55-49:55) Written testimony #8 President of the ND Psychiatric Society. She spoke in support of this bill. We particularly like the patient license. Covers our side of the patient care. The way it is phrased this is how we understand it. As a contact between two people where they form a trust bond. I don't know how we can make this kind of relationship with a questionnaire. As a psychiatrist and scientist the American Psychiatric Association released guidelines and they just say about video conferencing based on mental health. What's the evidence for the audio conference part? There is one single review and I would gladly like to be educated on this matter. There is solid evidence for establishing physician patient relationship with video but not audio. This is something we hope to develop more and more in this state.

Madam Chair Lee: We've been using tele-health with psychiatry and counseling in particular in order to solve some of the workforce shortages. This has nothing to do with access with the internet. It has to do with the fact there aren't enough professionals who want to live in a rural county. Do you think its valuable to see how the person is physically moving during the discussion or is that not as important?

Dr. Gabriela Balf-Soran: I formed good relationships with Hettinger, West River Health Services, mostly with Beulah, Dickinson, and I was at Sanford. Even places where yes where we need access to care and this is available. I do not see need for audio and do not see how this would be happening in a quality way.

Madam Chair Lee: In your appointments with somebody would you not, do you think it's valuable to be able to see another person who is moving or responding to what your discussion is or is that not as relevant as what there might be?

Dr. Gabriela Balf-Soran: I do appreciate so many other things that what we relate to what is called under status exam. Appearance and demeanor is what would an equivalent of a face to face interaction. This idea of therapeutic relationship is also about treatment. Do you know what the attrition rate of alcohol do you know how many people see a psychiatrist the second time after they fall. Its 70 percent of people drop out of therapy because they don't feel comfortable. We already have this huge drop- out rate.

Senator Anderson: Sometime we say that 50% of communication is body language. It's awfully difficult to pick up body language with audio and or filling out a questionnaire. I agree with you that it's very important when you're talking about those things.

Dr. Gabriela Balf-Soran: In my years at Yale my director was the president of the association for their emergency room physicians and was writing a book and one big chapter was about finger nails.

Madam Chair Lee: Asks for any more testimony. Closes hearing on SB 2094

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Minutes: No Attachments

(03:22) Senator K. Roers: I just kind of want to remember where we were at. Have we already made the amendment on the prescribing piece?

Madam Chair Lee: I have no amendments. We have an amendment that was proposed about the 24 hours to 7 days, and of course the discussion on whether "video" should be in there or not and "with the exception of hospitalized patients or nursing homes" that one I think there wasn't any debate about.

Senator Hogan: Do you want to consider the opioids may not be prescribed through telehealth with the exception of patients in hospital or long term care? We actually have a written amendment.

Madam Chair Lee: Who presented it?

Senator K. Roers: We just had it typed up. I believed that the 7 day amendment, Senator Anderson found that there was an exception in another part of law that negated the need for that amendment.

Madam Chair Lee: I remember you talking about this, but we didn't have a conclusion.

Senator Hogan: Pam Sagness just shared that medication assisted treatment is using telehealth and that she is working on an amendment to assure that is still covered. Could you get us an amendment because I don't think we had formal discussion on that?

Senator Anderson: As long as we are talking about SB 2094, one option to solve the questions that people have about the term "a video". What I am looking at is the possibility that we might look at the definition on page 2 line 14 & 15. In place of the word "a video" we will say that "a direct interactive patient encounter, asynchronous store-and-forward

technology or remote monitoring examination utilizing appropriate….” Then just continue from there. Pull the words from the definition and replace “video” and I think that they can accomplish the same thing the board is looking to do using that definition then pull out the “a video”. I haven’t seen Jack McDonalds definition of asynchronous store-and-forward technology; did you get that yet?

Senator K. Roers: No.

Senator Anderson: When we finally work on that bill I think I’d like you to mull that over and maybe see if that will work.

Madam Chair Lee: We have at least four that we would like to include.

Senator K. Roers: We had someone who just got here for SB 2030 can we just submit the written testimony for the record?

Madam Chair Lee: We can allow you Kurt to tell us about it if you would like.

(09:13) Madam Chair Lee and the Senate Human Services Committee moves on to hear testimony on SB 2030.

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB2094
1/15/2019
Job # 30837

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to the practice of tele-medicine;

Minutes: No Attachments

Madam Chair Lee: We have the amendment on opioids. Pam is bringing me, us the medically assisted treatment one tomorrow. That's why we're waiting on that one. Once we get that and we want to have informal discussion about the opioids may not be described through tele-medicine encounter for any other purpose with the exception of patients in a hospital or long term care facility. I think we all were in consensus on that. Also, on the change from 24 hours/7days with some question about that one. We were going to use possibly the language from page 2 line 14 and 15 instead of video. As soon as we find out what the definition of that long description is.

Senator Anderson: Madam Chair, explain to us how it works if we amend a bill more than one time in this committee, when it comes to the floor on the 6th order do we just handle all the amendments at one time?

Madam Chair Lee: Why wouldn't we just have them all in one amendment? That's why I would like to hang on. We can further amend and further amend but on the floor we don't want to do that. So if we have agreed on the other part and we have on opioids and the 7 days and we either wait for Pam on the medical issues, but that definition of video and then whether or not we have the video in there. The big dichotomy on this one is are we going to let them do videos or not. Here is my general approach to these tv kinds of things is that I think that telehealth is terrific and we've been using it for years. I know it will only grow. But I think it better to consider being a little tighter at the beginning and in 2 years we can loosen it up a little bit if we find that it's too restrictive. When we see how it's working we can never go the other way.

Senator Anderson: Just to tell you a little story. When we started doing tele-pharmacy in 2003, we initially required everybody whose tele-pharmacy over a distance to use video. They had to have audio, video, and a common computer system. Now later on some out of state providers who wanted to do tele-pharmacy said we'd like to do this but we just don't want to do the video for various other reasons. I remember the Dean at the College of

Pharmacy Peterson and I worked very closely on drafting the Office for the Advancement of Telehealth federally guidelines for tele-pharmacy. The Dean said I think we should stick with video, and I was just about to go the other way. We did stick with video and it became the standard for the whole country. Now every tele-pharmacy operation in the whole country uses our model. These software companies who wanted to get by without the video now have video even on the little dispensing machine that they might put into the hospital they have a video component so you can call up the pharmacist and you can talk to them. Even in the hospitals with the nurses there, we require the video and that way if the nurse wants to show the pharmacist what she actually picked up to use on this patient she can do that or if the practitioner who wrote the order wants to consult with the pharmacist they can do that and show the products they intend to use and so forth. So if it happens to be the wrong one they can even see that. So it became the standard because we said, we're going to stick with that. That is just an example of how you can be the leader in something if you stick with what you think is the best way to do it.

Senator Hogan: As I read the letters that Bonnie introduced from all of the physicians I think that medical visual evaluation and it's only the first time and people who seem to opposed it were mostly out of state groups who are doing contract work. It's very interesting to me that the local people seemed to be pretty committed to this video standard.

Madam Chair Lee: Psychiatrists were very strong. They were kind of influential in my thinking.

Senator K. Roers: They have a separate set of standards as what I understood from hers and they have a higher level of standards due to the difference in their care. So I am doing a little research here so the Center for Connected Health Policy is who defines what a synchronized storm forward is. Synchronous would mean we are talking in real time. A synchronous just means we're not talking in real time, then the storing forward is the ability and the examples that they give is the ability of the practitioner to be able to review the data before they then respond, so they have that opportunity to look at an x-ray, test results, etc. So it sounds like its non-real time but I believe that when they use this asynchronous going forward its building in the robustness of some of the privacy pieces of it, rather than the actual technology of it.

Senator O. Larsen: If I can expound on this story with Sen. Anderson with the company and groups that I run enrollment platform and the one particular platform when I have over 1500 lives on it. I offer a video conference when somebody enrolls so they get on line if they don't understand to pick their product, if there is any confusion at all. I have 16 agents in Omaha that one of them will come up and it will be a live interaction and they will walk them through the whole process of enrollment and answer any questions. I don't believe it was recorded that anybody can access that information. To me it seems like a great selling tool in my industry that people want to be at ease and they want to have that communication back and forth as compared to the enrollment platform that I have that is with 500 lives or less that is purely just a portal where you select your product, watch a video but there is no physical agent that will come on board and just walk you through it through the computer. I where they are coming with that part on there. I also was wondering though when they said on that line if they said "an" that they could use it or not on that one page. I don't remember the number. But they said if we replace that video with the word "an" and then Senator Anderson's

definition in that other section that would, they could use the psychologists could use the video if she so chose and somebody else could their way if they wanted to.

Senator Anderson: I am comfortable with the two amendments that we have and just go ahead and approve it with the video. Now there is some risk it might not survive, with that language.

Madam Chair Lee and Senate Human Services Committee moves on from SB 2094 to SB 2198.

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2094
1/16/2019
Job # 30874

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to the definitions of the practice of medicine and telemedicine and the practice of medicine.

Minutes: No Attachments

Pam Sagness: Relating to the telehealth amendment that was offered regarding opioids, so I didn't draft this as a full amendment because it would be a change to an already proposed amendment so instead I offer just language that you can have. It's the language that mirrors what the board of medicine adopted, specific to telemedicine and the prescribing of opioids. Id like to just read the sentence and if you would like to include that in your already proposed amendment than you could just use the language. "Opioids may only be prescribed through a telemedicine encounter if they are done so as an FDA approved medication assisted treatment or MAT for opioid use disorder. Opioids may not be prescribed through a telemedicine encounter for any other purpose." That is the language for everyone to be aware of through the board of medicine. What we would want to do is just focus on that FDA approved medication so that if it is only for nursing homes or certain areas we don't also take away the opportunity for opioid treatment programs for providing treatment. As Senator Anderson said there's incredible oversight for this program, so there is a lot of work around reducing diversion.

Madam Chair Lee: If you could get a copy to Justin (Committee Clerk).

Pam Sagness: Yes, I have already sent you the language in an e-mail, so I can send it to Justin.

Madam Chair Lee: Ok, that would be wonderful. We will be chatting about this sometime this afternoon so in case your around you may be able to sit in. Anything further?

Madam Chair Lee closes the discussion on SB 2094

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2094
1/16/2019
Job # 30923

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to the definitions of the practice of medicine and telemedicine and the practice of medicine.

Minutes: No Attachments

John Ward, Attorney, representing Teladoc.

John Ward: I do have an amendment, I have e-mailed a copy to Senator Anderson and gave one to Senator Hogan shortly before this committee work here so I could hand this out. If the intern would like a copy as a word document, we can do send that over. Essentially what that amendment would do, would include the asynchronous store-and-forward language in addition to the video component of it. It also kind of lays out what some of those additional requirements at the initiation stage could look like. This proposed amendment sort of originates the way the Texas statute is written and is similar in several other states. I think there was some confusion at the original hearing with respect to the statement made by the Federation of State Medical Boards to this committee specifically referring to that there are 17 or so states that have language along the lines of the bill that's proposed by the board of medicine and I think that's absolutely correct. The distinction that we were getting at was that to our knowledge there are two states that have the video only requirement and those states are Delaware and Arkansas. The difference would the 17 states would have the video and the store-and-forward technology language in there.

Madam Chair Lee: The others have both is what you're telling us?

John Ward: Yes, that is correct.

Madam Chair Lee: So if I'm going to value up and you're my provider. Tell me, I have a belly ache, tell me what you are going to be using asynchronous store-and-forward technology in conjunction with synchronous audio interaction between the practitioner and the patient in another location.

John Ward: I'm not a physician so I can't answer any of the diagnostic questions, but the way that I understand it is the asynchronous store-and-forward technology essentially what

asynchronous means not at the same time and the synchronous means like in a video or audio conversation between the physician and the patient that's synchronous. The asynchronous component to that would be any additional data. As this amendment is written it would have "could include clinically relevant photographic or video images" so if the patient were to upload through the telemedicine platform beforehand some high resolution photographs or if they have a video that they have uploaded which could also include diagnostic images or the patient's relevant medical records such as their medical history, laboratory and pathology results, and any prescriptive histories. Senator K. Roers did point out that prescriptive is actually spelled wrong so we need to put a "p" in there. So that would sort of be the distinction, so that it's clear that what we are talking about here is not just a telephone call that it's a telephone call plus the additional information in their discretion would deem necessary to formulate a diagnosis. Certainly, this is not going to be perfect in every instance. I think there is a huge body of medical practice that's probably not even appropriate in telemedicine. Yesterday I attended a committee work there was an either a cardiologist or a cardiothoracic surgeon that was here.

Madam Chair Lee: Yes, the Dean of the Medical School.

John Ward: I think he indicated that certainly his area of practice that he can't really do what he does in a telemedicine visit but that he believes in certain circumstances that it was appropriate and Senator Hogan and I had a chance to talk briefly about this and she had caught him out in the hall after and he had said that he thought that maybe in 5-10% of medicine that you could utilize this store-and-forward technology and the synchronous audio component of that as well in treating. That may not seem like a lot but if you consider if there were 100,000 telemedicine visits to a current state, if you are talking about 5,000-10,000 of them that's a pretty significant amount. If this is an additional tool that's available to a practitioner and their license they are practicing within the standard of care and they are using their discretion, they believe they have enough information that's available to them to treat this individual then they can. Otherwise I think will become appropriate and probably many telemedicine encounters if it's something that they can't do through telemedicine then they can refer their patient to a traditional in person visit.

Madam Chair Lee: I don't have problem with physician referrals to telemedicine. I think telemedicine is great and in fact I had a meeting with a Fargo area doctor over the weekend and he just said all docs are going to be replaced by algorithms anyways so it's not going to matter soon. The point is my concern is more that some person sitting in their kitchen in their pajamas will be much more interested not putting on a real pair of pants and going to see a same day clinic provider or something like that. The psychiatrist actually talked a little about that, that it would not be really good for her practice but my concern is if we aren't a little bit prescriptive in the way were asking for these things to be implemented if something is going to be missed in the interest of expediency, not necessarily for the physician so much as that the patient is saying when I have time I can just send an e-mail and there will be other things that the provider isn't going to see because they can't see the person. That's where I'm coming from its not that the doctors aren't qualified and capable and interested in doing the right thing. My concern is that someone has an initial contact with a medical provider is going to not be seen by that person in some way and all the other symptoms that a doctor or nurse practitioner can recognize when seeing the person even with one video view, that's important. It isn't that I'm trying to fight the idea we are going to have telehealth available

here that's not it at all, we just need to figure out a way that makes it safe and appropriate for the patient and the provider.

Madam Chair and the Senate Human Services Committee end discussion on SB 2094

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2094
1/17/2019
Job # 31017

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to the definitions of the practice of medicine and telemedicine and the practice of medicine.

Minutes: No Attachments

Madam Chair Lee: SB 2094 is all of that stuff from the hospitals association ready?

Senator Anderson: We already have a provision when there is another practitioner is present the consultation can be performed by any other doctor it doesn't even have to be a ND licensed physician the consultation can be performed so I think she assuming that needed to be included in this but I really don't think so.

Madam Chair Lee: I think your probably right.

Senator Anderson: Are we holding that open because the other side hadn't had a chance to get here yet?

Madam Chair Lee: Yes, we are holding it open for Monday afternoon, im just trying to catch up here. Doctor **(inaudible)** had some concerns and so he was the one who wanted to say "with the exception of hospitalized patients" which we just now got. We will hear the rest of SB 2094 on Monday afternoon.

Ends discussion on SB 2094.

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2094
1/21/2019
Job # 31122

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to the definitions of the practice of medicine and telemedicine and the practice of medicine.

Minutes: No Attachments

Madam Chair Lee: If we look at SB 2094 we have page 2 line 31, changing 24 hours to 7 days and page 3 line 23, "a video examination" will be replaced with "an examination" and then we move after "utilizing" we would then add "secure video conferencing or store-and-forward technology".

Senator Hogan: Does long term care facility include basic care or is it just skilled care?

Madam Chair Lee: Well, that's the only reason why I stopped talking is because maybe long term care may suggest DD facilities because it should.

Senator Hogan: Should it be skilled care?

Madam Chair Lee: Or do we want DD facilities included?

Senator Hogan: I think that's a really interesting question that we haven't really talked about.

Senator Anderson: I think that we would consider when we say long term care we mean basic and skilled in North Dakota, and the key there is that there's a nurse in the basic care facility helping the patients administer their medication whereas assisted living facilities they are taking care of themselves and administering their own. In the basic care facility there shouldn't be the risk of diversion by others and so forth. I don't think you need to restrict it; I think basic care would be included.

Madam Chair Lee: The thing with assisted living is that it isn't even regulated the same way, it's a residential model and not a medical model and so I agree with Senator Anderson.

Senator Anderson: I would suggest that maybe before we act on it that we run it by the medical board.

Madam Chair Lee: I just wanted us to have a chance to talk about it and they can add anything.

Madam Chair Lee and the Senate Human Services Committee move on to discuss SB 2154.

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2094
1/22/2019
Job # 31218

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to the definitions of the practice of medicine and telemedicine and the practice of medicine.

Minutes: No Attachments

(00:30) Bonnie Storbakken, Executive Secretary for the State Board of Medicine: The first amendment was on line 31 page 2, and that was to strike "24 hours" and add "7 days". Our board was actually able to discuss that at the last meeting and they are in favor of that. The second amendment on page 3 to strike "video". I wasn't able to discuss these amendments with our board, our board doesn't meet until Friday and I have been trying to get a quorum and that is the soonest I can get them assembled. I can't say that we would support this language, I can say that this was the bone of contention for a long time and our board was very committed to this language even though, it is in excess of what the model language of the FSMB (Federal State of Medical Boards) and the AMA (American Management Association) states. I would say that I understand where Senator Anderson is coming from with these amendments and its basis. I think it is accurately within what the FSMB and the AMA is saying, our board is more conservative is what I would say.

Senator Anderson: The other amendment is to add opioids in long term care and so forth.

Bonnie Storbakken: That one our board was able to review and they stood in favor of that.

Madam Chair Lee: And also about the patients in hospitals or long term care facilities.

Bonnie Storbakken: Yes.

Madam Chair Lee: So the only one that you really don't have consensus on would be the "video".

Senator K. Roers: Can I argue that this process is not over when we pass it and that if they do have that strong of an objection there is still another chamber.

Madam Chair Lee: Any other questions for Mrs. Storbakken? If not, thank you very much. Any quick discussion before we move onto the next one?

Senator K. Roers: Can we move on it?

Madam Chair Lee: We can if you wish.

Senator K. Roers: I move to ADOPT AMENDMENTS as just discussed.
Seconded by Senator Hogan

Madam Chair Lee: Discussion on the amendments?

Senator Anderson: I proposed that amendment as a possible alternative for consideration by the Board of Medicine. I'm not sure if the Board of Medicine doesn't want the amendment in that form that I would support it. I am sensitive to what we can accomplish on the other side and if we want a clear definition of Telemedicine I know that there are members who are on the administrative rules committee that had the rule held up for this various issue and they're a little more adamant in the house. It might get changed over there regardless of what we do.

Senator K. Roers: Where I struggle with the original language is that the law is to set the floor. This is not necessarily to define the ideal. I struggle with making it too tight. We had multiple people come and testify and say that this is not the standard across the U.S., this is far more stringent and it doesn't mean that we don't want to do something more stringent but I also want to make sure that we don't make it so tight that we aren't able to be flexible as life and technology changes.

Madam Chair Lee: The other thing I would mention about the administrative rules committee is that my understanding is that they wouldn't support it, and I don't have anything in writing about this but, rather that they thought this was a legislative decision of discussion and that's why it needed to be here. It isn't that they were for or against, they thought that it was not their place and I appreciate them recognizing that there was a reason for legislative discussion.

Senator Hogan: The question is; the urgency to get a bill moved out versus having to do a conference committee in two months which is a time concern too, so perhaps we should hold this until we hear on Monday, and at least we know what we are doing.

Madam Chair Lee: If they don't like it, then what?

Senator Hogan: If they don't like it, then we make the decision based on the policy issue.

Madam Chair Lee: It's up to the committee. We have an amendment before us which has been seconded.

Senator K. Roers: So are there any feelings of tabling the amendment?

Madam Chair Lee: We can even approve the amendments and leave the votes until Monday, but I realize this is Tuesday and we would be delaying this a whole week.

Senator O. Larsen: For clarification on line 23 page 3 that would have left out and the other three amendments would.

Madam Chair Lee: No, what we would have is on page 3 line 23 it would say the word "video examination" would be removed but it would be replaced by "an examination" and then it would be utilizing "secure video conferencing or store-and-forward technology".

Senator O. Larsen: So page 2 line 31 we are leaving out.

Madam Chair Lee: We aren't leaving out anything

Senator K. Roers: I'm only seeing three not four.

Madam Chair Lee: There are four on this dummy amendment. Two of them have to deal with the same sentences. One line says we are removing the next line says we are adding, so we have three places where there are changes we have four lines on the dummy amendment that are describing what those changes are.

Senator O. Larsen: I like that.

Madam Chair Lee: Any discussion on the amendment? If not, please call the roll.

ROLL CALL VOTE TAKEN
5 YEA, 1 NAY, 0 ABSENT
MOTION CARRIES TO ADOPT AMENDMENTS

Madam Chair Lee: If you would prefer having that amendment in place to wait until Monday to vote on it that's ok but, that is six days from now that is all I am saying.

Senator O. Larsen: I move **a DO PASS, AS AMENDED.**
Seconded by Senator Clemens

Madam Chair Lee: Any discussion on the amended motion? If not, please call the roll.

ROLL CALL VOTE TAKEN
6 YEA, 0 NAY, 0 ABSENT
MOTION CARRIES DO PASS, AS AMENDED.

Madam Chair Lee closes the discussion on SB 2094 and moves on to SB 2333.

Adopted by the Human Services Committee

SK 1561

January 22, 2019

PROPOSED AMENDMENTS TO SENATE BILL NO. 2094

Page 1, line 2, remove "subsection 3"

Page 1, line 3, remove "of section 26.1-14-02 and"

Page 1, remove lines 7 through 10

Page 2, line 31, overstrike "twenty-four hours" and insert immediately thereafter "seven days"

Page 3, line 23, replace "A video" with "An"

Page 3, line 23, after "utilizing" insert "secure videoconferencing or store-and-forward technology for"

Page 4, line 20, after "disorder" insert "or to a patient in a hospital or long-term care facility"

Renumber accordingly

Date: 1/22/19
Roll Call Vote #: 1

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2094

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 19.8055.01001

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen K. Roers Seconded By Sen. Hogan

Senators	Yes	No	Senators	Yes	No
Chair Lee	X		Senator Hogan	X	
Vice Chair Larsen	X				
Senator Anderson		X			
Senator Clemens	X				
Senator Roers	X				

Total (Yes) 5 No 1

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 1/22/19
Roll Call Vote #: 2

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2094

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. O. Larsen Seconded By Sen. Clemens

Senators	Yes	No	Senators	Yes	No
Chair Lee	X		Senator Hogan	X	
Vice Chair Larsen	X				
Senator Anderson	X				
Senator Clemens	X				
Senator Roers	X				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen. Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2094: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2094 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "subsection 3"

Page 1, line 3, remove "of section 26.1-14-02 and"

Page 1, remove lines 7 through 10

Page 2, line 31, overstrike "twenty-four hours" and insert immediately thereafter "seven days"

Page 3, line 23, replace "A video" with "An"

Page 3, line 23, after "utilizing" insert "secure videoconferencing or store-and-forward technology for"

Page 4, line 20, after "disorder" insert "or to a patient in a hospital or long-term care facility"

Renumber accordingly

2019 HOUSE HUMAN SERVICES

SB 2094

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2094
3/25/2019
Job #34213

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Nicole Klaman	By: Carmen Hickle

Explanation or reason for introduction of bill/resolution:

Relating to the practice of telemedicine, relating to the definitions of the practice of medicine and telemedicine.

Minutes: 1,2,3,4,5,6

Chairman Weisz: Opened the hearing on SB 2094.

Bonnie Storebakken, **Executive Secretary for the ND Board of Medicine**: (Attachment #1) Discussed supportive points and proposed amendment changes they would like to see. This bill attempts to provide parameters for our licensees regarding the practice of telemedicine and provide the structure necessary to fulfill the mission of the Board to protect the public through the regulation of the Practice of Medicine.
0:18:32

Rep. Skroch: On page 3, line 10, it talks about "valid relationship" but that is not defined in the definitions section. I don't see anything else that constitutes a valid relationship, should we be defining so we don't have a loophole in this bill?

Bonnie Storebakken: That is a good point but when you get down to the subsection in 3, that is the attempt to define how a valid relationship would be established. It is our position that you leave it as "or store-and-forward technology" would be important. That paragraph talks to how that relationship is established.

Rep. Skroch: On page 3 line 10, I believe bonafide relationship is defined in other sections of the code. I wonder if it would work as well as "valid relationship" instead use "bonafide relationship"? Rather than try to redefine another term?

Bonnie Storebakken: Yes, I would have no objection.

Rep. Tveit: I question whether the initial visit shouldn't be done in person?

Bonnie Storebakken: We discussed this and our Board was comfortable with the video or another provider in the room with the patient who could communicate that information. A telephone only or a questionnaire only that opens the door to concerns us for patient safety.

Rep. Tveit: Can a telemedicine doctor become a marijuana prescriber?

Bonnie Storebakken: Yes, there is nothing that would prohibit a physician under this rule from prescribing or from recommending medical marijuana.

Rep. Skroch: Is this to deal with doctor shortages?

Bonnie Storebakken: The bill is coming to you because telemedicine is happening. This provides our licensees with parameters so they know what they can do and what shouldn't be done. Right now it is open except for the prescribing.

Rep. Skroch: Could you give me examples? I'm wondering about procedures, would there be a less qualified provider that could be guided remotely to do a procedure by a higher trained provider? You have one professional with the patient and another more highly trained individual guiding them through telehealth.

Bonnie Storebakken: It sounds as you are speaking about a medical procedure. Speaking from a board perspective, we would hope that anyone doing a medical procedure is qualified to do so.

Brenda Miller, **Licensed Physician**: (**Attachment 2).** Dr. Miller stated the safety of the patient is very important and feels that with telemedicine it's been important to put some parameters in the visual contact. The visual component the board has been adamant about keeping. It should have been put forth in the original bill.

Laura Kroetsch, **Licensed Psychiatrist**: (Attachment #3). She read her written testimony and discussed her proposed amendments.
(0:33:36)

John Ward, representing Teladoc Health: **(Attachment 4).** He read his testimony.

Claudia Duck Tucker, **V.P. of Government Affairs for Teladoc Health**: **(Attachment 5).**
(0:48:39)

Courtney Koebel, **North Dakota Medical Association**: (**Attachment 6)**. They support the bill with the amendments as suggested by the North Dakota Board of Medicine with the addition of her amendments as well. She highlighted a handout from Dr. Mary Ann Sens. Dr. Sens supports an amendment to add on 43-17-02.3 "on a diagnosis for a patient to a physician licensed in the state".

Chairman Weisz: Closed the hearing.

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2094 A
3/26/2019
34242

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Nicole Klaman

Explanation or reason for introduction of bill/resolution:

Relating to telemedicine

Minutes:

Chairman Weisz: Opened meeting

Chairman Weisz: We have a couple amendments to discuss.

(0:03:58)
Rep. Porter: What is the best thing for the people of ND?

Rep. Rohr: Keep in mind urban vs rural health care needs.

Rep. Tveit: For clarification, store and forward, does that include any previous history? Can you use previous information to get a new prescription?

Chairman Weisz: My understanding of store and forward, is data. It doesn't have to be in live stream, any medical history or records would or could be used to make the diagnosis. It doesn't require any face to face from a standpoint of video or audio. Montana requires 2 way active video.

Rep. Tveit: With today's technology it wouldn't be difficult to have a face time with that doctor and they have the ability to look back into your history. I don't know if the store and forward needs to be there.

Chairman Weisz: Subsection 2 does require they establish a valid relationship and the doctor's licensure status must be verifiable. I don't know if that helps on the level of establishing that relationship?

Rep. Porter: I move the amendment

Rep. Tveit: Second

Rep. M. Ruby: I am going to resist the amendment. Where I see store and forward coming in in the rural areas. If a rural patient can't get to an urban area for an appointment but can get to a local clinic for evaluation. This can then be forwarded to the doctor in the urban area for review.

Chairman Weisz: It can be used that way, but it wouldn't require they be evaluated elsewhere.
This amendment would remove the ability to use store and forward. It would require a face to face, video or to be present.

Voice Vote: Undetermined

Roll Call Vote: to adopt amendment Yes 6 No 8 Absent 0
Motion failed

Chairman Weisz: Any further amendments?

Rep. Porter: Dr. Sens' Amendment; page 2 line 23 after "consultation" insert "on a diagnosis for a patient to a physician licensed in the state or teaching assistance not more than a period of 7 days."
I move to adopt this amendment.

Rep. M. Ruby: Second

Voice Vote-Motion carried

Rep. Porter: The amendment I'm proposing I had conversations with Ms. Storbakken about and she's had conversations with radiology in the past. Inside the board of medicine, one of the areas that we missed as we created the board of medical imaging was removing, page 2 sub 11, out of the board of medicine's century code list. You will see on sub 14 an individual license for medical imaging in the state under chapter 43.62 is exempt from the board of medicine. For some reason we left the fluoroscopy person inside of here, which was old language prior to the board of medical imaging. We have conflicting language, so this would just be a clean-up inside their practice act. It would create a new section 5 of 43-17.02 removing sub 11. It would be clear, even though exempt from the practice act, that they aren't listed inside of this any longer.
I would move that amendment.

Rep. M. Ruby: Seconded.

Chairman Weisz: Further Discussion? Seeing none.

Voice Vote: Motion carries.

Rep. Skroch: Page 3, line 2 changing "valid" to" bonafide.

Rep. Anderson: Second

Voice Vote: Motion carried

(0:21:28)

Rep. Anderson: I'm adding my bill to this one regarding the hyperbaric chambers was dramatically changed, changing the intent of my bill. On line 11, I replaced "local nonprofit entity" to "entity" and line 14 "private entity" with "entity". The Senate Human Service committee didn't like that it looked like it was directing the money so I changed the language so they would be a pathway for the money to flow.

Chairman Weisz: Your amendment probably isn't want you want. This is a hog house amendment. Which means 2094 goes away.

Rep. Anderson: Can I add it on it?

Chairman Weisz: Just so we are clear if we adopt this, we will have to eliminate "to replace a bill" your amendment would get rid of 2094. If we do adopt it, we would have to add it to a new section of the bill.

Rep. Porter: If you just cross out section 1 and replace with section 6.

Chairman Weisz: I want to be clear we didn't just adopt this.

Rep. Schneider: I think it could be done with a section 6 and add hyperbaric chamber in the description.

Chairman Weisz: I hadn't looked at it until Seth mentioned it's a hog house.

Rep. Skroch: Do we need a fiscal note?

Chairman Weisz: It would be rereferred to appropriations.

Rep. Damschen: I'm really torn on this because I really like the hyperbaric oxygen therapy. I've also been very adamant against adding defeated bills to another bill. I want to support it but don't know if I can and still be mad at somebody else for doing it.

Rep. Anderson: It still hasn't been voted on in the senate completely. It will be going back to appropriations.

Rep. Damschen: It hasn't been on the floor yet.

Rep. Anderson: Yes, it has but they added amendments. They have not voted on the whole bill. It bothers me doing this, but I also know this study will save the state a lot of money. This is why I haven't given up yet. I don't think they understood what the intent of the bill was.

Rep. Skroch: I move the amendment to add to section 6 of the bill.

Rep. Anderson: Seconded.

Voice Vote: Motion Carries.

Rep. M. Ruby: I move a Do Pass as amended rerefer to Appropriations.

Rep. Porter: Seconded.

Roll Call Vote: 14 Yes 0 No 0 Absent

Rep. Anderson: Will carry bill.

Chairman Weisz: Hearing closed.

Honorable Members of the ND House Human Services Committee:

I am Dr. Mary Ann Sens, a pathologist working and teaching at the University of North Dakota School of Medicine and Health Sciences. I have resided in Grand Forks and held a ND medical license since 2002.

I wish to support an amendment to Senate Bill 2094. Along with the ND Board of Medicine and the ND Medical Association, I strongly support the concept and direction of this legislation and believe it protects North Dakota patients. However, one area needs clarification. In Section 43-17-02.3.3, the concept of "one time consultation" should be clarified by the addition of the highlighted text below:

> ***43-17-02.3. Practice of medicine or osteopathy by holder of permanent, unrestricted license - Exceptions .***
> *The practice of medicine is deemed to occur in the state the patient is located. A practitioner providing medical care to a patient located in this state is subject to the licensing and disciplinary laws of this state and shall possess an active North Dakota license for the practitioner's profession. Notwithstanding anything in this chapter to the contrary, any physician who is the holder of a permanent, unrestricted license to practice medicine or osteopathy in any state or territory of the United States, the District of Columbia, or a province of Canada may practice medicine or osteopathy in this state without first obtaining a license from the North*
> *Dakota board of medicine under one or more of the following circumstances:*
> *1. As a member of an organ harvest team;*
> *2. On board an air ambulance and as a part of its treatment team;*
> *3. To provide one-time consultation* ***on a diagnosis for a patient to a physician licensed in the state*** ***or*** *teaching assistance for a period of not more than seven days; or*
> *4. To provide consultation or teaching assistance previously approved by the board for charitable organizations.*
> ***SECTION 3.*** *Section 43-17-44 .....*

This is important in some areas of medicine, including pathology, but is also applicable to other complex consultations. It is common for pathologists to seek expert consultation on unusual or difficult cases; these consultations between pathologists involve sending slides, lab test results and/or other material to an expert who may be in any state (or country). Some tumors and other conditions are so rare or may require confirmatory testing done only in a few places; it is the standard of care within pathology to seek expert consultation for the best patient care and accurate diagnosis, including those out of state.

At present, the bill stipulates one-time consultation. Does the "one-time" mean that an out-of-state physician can only consult one time to that physician (for a period of seven days) and then never again? That would be the literal interpretation of the provision as it currently reads. This would be a significant deterrent to any physician specialist in another state in consulting with North Dakota physicians.

This amendment makes it clear that "one-time" applies to a particular patient for a particular time. This will allow full utilization of expert specialty consultants for North Dakota patients as deemed appropriate by practicing North Dakota physicians. Although this may intuitively seem the intent of the law and that this situation would be uncommon, it is actually very common in pathology and perhaps other specialties of medicine. This assures diagnostic excellence for North Dakota patients and North Dakota physicians allowing expert consultation when it is needed for diagnosis and treatment options.

PROPOSED AMENDMENT TO ENGROSSED SENATE BILL NO. 2094

Page 4, after line 23, insert a new section:

Section 5. Section 43-17-02 of the North Dakota Century Code is amended and reenacted as follows:

~~11. A person rendering fluoroscopy services as a radiologic technologist if the service is rendered under the supervision, control, and responsibility of a licensed physician and provided that the North Dakota board of medicine prescribes rules governing the conduct, permits, fees, qualifications, activities, discipline, and supervision of radiologic technologists who provide those services.~~

Prepared by the Legislative Council staff for
Representative D. Anderson
March 20, 2019

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2094

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a hyperbaric oxygen therapy pilot program; to provide an appropriation; and to provide for a report to the legislative management.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. APPROPRIATION - HYPERBARIC OXYGEN THERAPY PILOT PROGRAM - REPORT TO LEGISLATIVE MANAGEMENT.

1. There is appropriated out of any moneys in the tobacco prevention and control trust fund in the state treasury, not otherwise appropriated, the sum of $335,000, or so much of the sum as may be necessary, to the state department of health for the purpose of contracting with a third party to implement a hyperbaric oxygen therapy pilot program, for the biennium beginning July 1, 2019, and ending June 30, 2021.

2. The department shall contract with an entity with experience implementing studies using hyperbaric oxygen for traumatic brain injuries to conduct a pilot program for treatment of moderate to severely brain-injured North Dakotans using an established protocol of hyperbaric oxygen therapy provided by an entity with experience in treating traumatic brain injury using medical-grade hyperbaric chambers pressurized with one hundred percent oxygen. The goals of the study include demonstrating improvement in brain-eye function using RightEye, significant improvement in quality of life of injured patients, significant improvement in cognitive abilities of injured patients, and financial savings and increased revenues for the state, including possible savings for medical assistance and workers' compensation and a positive impact on income tax revenues. The pilot program design must be established in consultation with a third-party physician.

3. During the 2019-21 biennium, the department shall make periodic reports to the legislative management on the status of the pilot program and whether the goals are being realized."

Renumber accordingly

Adopted by the House Human Services Committee

March 26, 2019

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1 of 3

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2094

Page 1, line 2, remove the first "and"

Page 1, line 3, after "43-17-01" insert ", 43-17-02,"

Page 1, line 4, after the second "medicine" insert "; to provide for a hyperbaric oxygen therapy pilot program; to provide an appropriation; and to provide for a report to legislative management"

Page 2, after line 8, insert:

"**SECTION 2. AMENDMENT.** Section 43-17-02 of the North Dakota Century Code is amended and reenacted as follows:

43-17-02. Persons exempt from the provisions of chapter.

The provisions of this chapter do not apply to the following:

1. Students of medicine or osteopathy who are continuing their training and performing the duties of a resident in any hospital or institution maintained and operated by the state, an agency of the federal government, or in any residency program accredited by the accreditation council on graduate medical education, provided that the North Dakota board of medicine may adopt rules relating to the licensure, fees, qualifications, activities, scope of practice, and discipline of such persons.

2. The domestic administration of family remedies.

3. Dentists practicing their profession when properly licensed.

4. Optometrists practicing their profession when properly licensed.

5. The practice of christian science or other religious tenets or religious rules or ceremonies as a form of religious worship, devotion, or healing, if the person administering, making use of, assisting in, or prescribing, such religious worship, devotion, or healing does not prescribe or administer drugs or medicines and does not perform surgical or physical operations, and if the person does not hold out to be a physician or surgeon.

6. Commissioned medical officers of the armed forces of the United States, the United States public health service, and medical officers of the veterans administration of the United States, in the discharge of their official duties, and licensed physicians from other states or territories if called in consultation with a person licensed to practice medicine in this state.

7. Doctors of chiropractic duly licensed to practice in this state pursuant to the statutes regulating such profession.

8. Podiatrists practicing their profession when properly licensed.

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9. Any person rendering services as a physician assistant, if such service is rendered under the supervision, control, and responsibility of a licensed physician. However, sections 43-17-02.1 and 43-17-02.2 do apply to physician assistants. The North Dakota board of medicine shall prescribe rules governing the conduct, licensure, fees, qualifications, discipline, activities, and supervision of physician assistants. Physician assistants may not be authorized to perform any services which must be performed by persons licensed pursuant to chapters 43-12.1, 43-13, 43-15, and 43-28 or services otherwise regulated by licensing laws, notwithstanding the fact that medical doctors need not be licensed specifically to perform the services contemplated under such chapters or licensing laws.

10. A nurse practicing the nurse's profession when properly licensed by the North Dakota board of nursing.

11. ~~A person rendering fluoroscopy services as a radiologic technologist if the service is rendered under the supervision, control, and responsibility of a licensed physician and provided that the North Dakota board of medicine prescribes rules governing the conduct, permits, fees, qualifications, activities, discipline, and supervision of radiologic technologists who provide those services.~~

~~12.~~ A naturopath duly licensed to practice in this state pursuant to the statutes regulating such profession.

~~13.~~12. An individual duly licensed to practice medical imaging or radiation therapy in this state under chapter 43-62.

~~14.~~13. An acupuncturist duly licensed to practice in this state pursuant to the statutes regulating such profession."

Page 2, line 23, after "consultation" insert "on a diagnosis for a patient to a physician licensed in the state,"

Page 3, line 10, replace "valid" with "bona fide"

Page 4, after line 23, insert:

"SECTION 6. APPROPRIATION - HYPERBARIC OXYGEN THERAPY PILOT PROGRAM - REPORT TO LEGISLATIVE MANAGEMENT.

1. There is appropriated out of any moneys in the tobacco prevention and control trust fund in the state treasury, not otherwise appropriated, the sum of $335,000, or so much of the sum as may be necessary, to the state department of health for the purpose of contracting with a third party to implement a hyperbaric oxygen therapy pilot program, for the biennium beginning July 1, 2019, and ending June 30, 2021.

2. The department shall contract with an entity with experience implementing studies using hyperbaric oxygen for traumatic brain injuries to conduct a pilot program for treatment of moderate to severly brain-injured North Dakotans using an established protocol of hyperbaric oxygen therapy provided by an entity with experience in treating traumatic brain injury using medical-grade hyperbaric chambers pressurized with one hundred percent oxygen. The goals of the study include demonstrating

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improvement in brain-eye function using RightEye, significant improvement in quality of life of injured patients, significant improvement in cognitive abilities of injured patients, and financial savings and increased revenues for the state, including possible savings for medical assistance and workers' compensation and a positive impact on income tax revenues. The pilot program design must be established in consultation with a third-party physician.

3. During the 2019-21 biennium, the department shall make periodic reports to the legislative management on the status of the pilot program and whether the goals are being realized."

Renumber accordingly

Date 3-26-19
Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL SB 2094

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☒ undetermined

Motion Made By Rep Porter Seconded By Rep. Tveit

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman			Gretchen Dobervich		
Karen M. Rohr – Vice Chairman			Mary Schneider		
Dick Anderson					
Chuck Damschen					
Bill Devlin					
Clayton Fegley					
Dwight Kiefert					
Todd Porter					
Matthew Ruby					
Bill Tveit					
Greg Westlind					
Kathy Skroch					

Undetermined Roll Call Vote #2

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

- Remove ability to store & forward
Initial exam face to face

Date: 3-26-19
Roll Call Vote #: 2

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL SB 2094

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. Tveit

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman		X	Gretchen Dobervich		X
Karen M. Rohr – Vice Chairman		X	Mary Schneider		X
Dick Anderson	X				
Chuck Damschen	X				
Bill Devlin		X			
Clayton Fegley		X			
Dwight Kiefert		X			
Todd Porter	X				
Matthew Ruby		X			
Bill Tveit	X				
Greg Westlind	X				
Kathy Skroch	X				

Total (Yes) 6 No 8

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:
Remove ability of Store & forward
Initial Exam face to face

Motion Failed

Date: 3-26-2019
Roll Call Vote #: 3

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL No. SB 2094

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: Dr. Seng Amendment; page 2 line 23 after "consultation" insert "on a diagnosis for a patient to a physician licensed in the state or teaching assistance not more than a period of 7 days."

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. M. Ruby

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman			Gretchen Dobervich		
Karen M. Rohr – Vice Chairman			Mary Schneider		
Dick Anderson					
Chuck Damschen					
Bill Devlin					
Clayton Fegley					
Dwight Kiefert					
Todd Porter					
Matthew Ruby					
Bill Tveit					
Greg Westlind					
Kathy Skroch					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote: Motion Carried.

Date: 3-26-2019
Roll Call Vote #: 4

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL No. SB 2094

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: Remove page 2 sub 11, out of the board of medicine's century code list

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. M. Ruby

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman			Gretchen Dobervich		
Karen M. Rohr – Vice Chairman			Mary Schneider		
Dick Anderson					
Chuck Damschen					
Bill Devlin					
Clayton Fegley					
Dwight Kiefert					
Todd Porter					
Matthew Ruby					
Bill Tveit					
Greg Westlind					
Kathy Skroch					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote: Motion Carried.

Date: 3-26-2019
Roll Call Vote #: 5

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL No. SB 2094

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: Page 3, line 2 changing "valid" to" bonafide"

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Skroch Seconded By Rep. D. Anderson

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman			Gretchen Dobervich		
Karen M. Rohr – Vice Chairman			Mary Schneider		
Dick Anderson					
Chuck Damschen					
Bill Devlin					
Clayton Fegley					
Dwight Kiefert					
Todd Porter					
Matthew Ruby					
Bill Tveit					
Greg Westlind					
Kathy Skroch					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote: Motion Carried.

Date: 3-26-2019
Roll Call Vote #: 6

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL No. SB 2094

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: add to section 6 add and hyperbaric chamber in the description.

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Skroch Seconded By Rep. D. Anderson

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman			Gretchen Dobervich		
Karen M. Rohr – Vice Chairman			Mary Schneider		
Dick Anderson					
Chuck Damschen					
Bill Devlin					
Clayton Fegley					
Dwight Kiefert					
Todd Porter					
Matthew Ruby					
Bill Tveit					
Greg Westlind					
Kathy Skroch					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote: Motion Carried.

Date: 3-26-2019
Roll Call Vote #: 7

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL No. SB 2094

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 19.8055.02002

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. M. Ruby Seconded By Rep. Porter

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman	X		Gretchen Dobervich	X	
Karen M. Rohr – Vice Chairman	X		Mary Schneider	X	
Dick Anderson	X				
Chuck Damschen	X				
Bill Devlin	X				
Clayton Fegley	X				
Dwight Kiefert	X				
Todd Porter	X				
Matthew Ruby	X				
Bill Tveit	X				
Greg Westlind	X				
Kathy Skroch	X				

Total (Yes) 14 No 0

Absent 0

Floor Assignment Rep. D. Anderson

If the vote is on an amendment, briefly indicate intent:

Motion carries.

REPORT OF STANDING COMMITTEE

SB 2094, as engrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2094 was placed on the Sixth order on the calendar.

Page 1, line 2, remove the first "and"

Page 1, line 3, after "43-17-01" insert ", 43-17-02,"

Page 1, line 4, after the second "medicine" insert "; to provide for a hyperbaric oxygen therapy pilot program; to provide an appropriation; and to provide for a report to legislative management"

Page 2, after line 8, insert:

"**SECTION 2. AMENDMENT.** Section 43-17-02 of the North Dakota Century Code is amended and reenacted as follows:

43-17-02. Persons exempt from the provisions of chapter.

The provisions of this chapter do not apply to the following:

1. Students of medicine or osteopathy who are continuing their training and performing the duties of a resident in any hospital or institution maintained and operated by the state, an agency of the federal government, or in any residency program accredited by the accreditation council on graduate medical education, provided that the North Dakota board of medicine may adopt rules relating to the licensure, fees, qualifications, activities, scope of practice, and discipline of such persons.

2. The domestic administration of family remedies.

3. Dentists practicing their profession when properly licensed.

4. Optometrists practicing their profession when properly licensed.

5. The practice of christian science or other religious tenets or religious rules or ceremonies as a form of religious worship, devotion, or healing, if the person administering, making use of, assisting in, or prescribing, such religious worship, devotion, or healing does not prescribe or administer drugs or medicines and does not perform surgical or physical operations, and if the person does not hold out to be a physician or surgeon.

6. Commissioned medical officers of the armed forces of the United States, the United States public health service, and medical officers of the veterans administration of the United States, in the discharge of their official duties, and licensed physicians from other states or territories if called in consultation with a person licensed to practice medicine in this state.

7. Doctors of chiropractic duly licensed to practice in this state pursuant to the statutes regulating such profession.

8. Podiatrists practicing their profession when properly licensed.

9. Any person rendering services as a physician assistant, if such service is rendered under the supervision, control, and responsibility of a licensed

physician. However, sections 43-17-02.1 and 43-17-02.2 do apply to physician assistants. The North Dakota board of medicine shall prescribe rules governing the conduct, licensure, fees, qualifications, discipline, activities, and supervision of physician assistants. Physician assistants may not be authorized to perform any services which must be performed by persons licensed pursuant to chapters 43-12.1, 43-13, 43-15, and 43-28 or services otherwise regulated by licensing laws, notwithstanding the fact that medical doctors need not be licensed specifically to perform the services contemplated under such chapters or licensing laws.

10. A nurse practicing the nurse's profession when properly licensed by the North Dakota board of nursing.

11. ~~A person rendering fluoroscopy services as a radiologic technologist if the service is rendered under the supervision, control, and responsibility of a licensed physician and provided that the North Dakota board of medicine prescribes rules governing the conduct, permits, fees, qualifications, activities, discipline, and supervision of radiologic technologists who provide those services.~~

~~12.~~ A naturopath duly licensed to practice in this state pursuant to the statutes regulating such profession.

~~13.~~12. An individual duly licensed to practice medical imaging or radiation therapy in this state under chapter 43-62.

~~14.~~13. An acupuncturist duly licensed to practice in this state pursuant to the statutes regulating such profession."

Page 2, line 23, after "consultation" insert "on a diagnosis for a patient to a physician licensed in the state,"

Page 3, line 10, replace "valid" with "bona fide"

Page 4, after line 23, insert:

"SECTION 6. APPROPRIATION - HYPERBARIC OXYGEN THERAPY PILOT PROGRAM - REPORT TO LEGISLATIVE MANAGEMENT.

1. There is appropriated out of any moneys in the tobacco prevention and control trust fund in the state treasury, not otherwise appropriated, the sum of $335,000, or so much of the sum as may be necessary, to the state department of health for the purpose of contracting with a third party to implement a hyperbaric oxygen therapy pilot program, for the biennium beginning July 1, 2019, and ending June 30, 2021.

2. The department shall contract with an entity with experience implementing studies using hyperbaric oxygen for traumatic brain injuries to conduct a pilot program for treatment of moderate to severly brain-injured North Dakotans using an established protocol of hyperbaric oxygen therapy provided by an entity with experience in treating traumatic brain injury using medical-grade hyperbaric chambers pressurized with one hundred percent oxygen. The goals of the study include demonstrating improvement in brain-eye function using RightEye, significant improvement in quality of life of injured patients, significant improvement in cognitive abilities of injured patients, and financial savings and increased revenues for the state, including possible savings for medical assistance and workers' compensation and a positive impact on income tax revenues. The pilot program design must be established in consultation with a third-party physician.

3. During the 2019-21 biennium, the department shall make periodic reports to the legislative management on the status of the pilot program and whether the goals are being realized."

Renumber accordingly

2019 HOUSE APPROPRIATIONS

SB 2094

2019 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

SB 2094
3/28/2019
34354

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Risa Bergquist

Explanation or reason for introduction of bill/resolution:

Relating to the definitions of the practice of medicine and telemedicine and the practice of medicine; to provide for a hyperbaric oxygen therapy pilot program; to provide an appropriation; and to provide for a report to legislative management.

Minutes: Attachment 1

Chairman Delzer: Called the meeting to order for SB 2094

Representative Weisz: The only reason this bill is here is because of an amendment that adds some language for hyperbaric oxygen therapy. The house passed this earlier and the senate killed it so we are adding it in here. I handed out amendments and I'll ask you to adopt it, SB 2094 is basically the telemedicine bill and when we amended it there was a section having to do with imagining, we mended that out but we forgot to add the language for the Fluoroscopist technologist. This amendment fixes that. **(see attachment 1)** If the committee would adopt that amendment.

Chairman Delzer: Where does this amendment sit in the bill? Line 12? It would come in front of the hyperbaric oxygen. So hyperbaric oxygen will go to section 7 and all you did was take the exact same numbers from the house bill.

Representative Weisz: It hasn't died on the senate floor but they amended to the point that it isn't doing what it was intended to do. It allocated 100 thousand dollars to UND to do some research.

Representative J. Nelson: Could we address this in SB 2012 rather than in a policy bill that has to go to conference?

Representative Weisz: We are just trying to help out the bill sponsor, we don't care what bill it ends up in, the committee supported this bill very strongly.

Chairman Delzer: If we take it out and bring it to the floor before 2012, what happens on the floor? If we do that you might want to make sure the bill sponsor is aware of what is going on.

Representative Weisz: If that is the intent of the committee to put this into SB 2012 we are okay with that. We know it might not survive that way but it might not survive in here either.

Chairman Delzer: Further questions by the committee? Seeing none we will close this hearing.

2019 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

SB 2094
4/1/2019
34379

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Risa Bergquist

Explanation or reason for introduction of bill/resolution:

Relating to the definitions of the practice of medicine and telemedicine and the practice of medicine; to provide for a hyperbaric oxygen therapy pilot program; to provide an appropriation; and to provide for a report to legislative management.

Minutes:

Chairman Delzer: Called the meeting to order for BS 2094, this is a human service bill, it's the one at the request of the board of medicine. It's a telemedicine bill, everything I understand is the bill needs to go forward, it has the hyperbaric treatment in it. I think they will add that to SB 2012.

Representative J. Nelson: There's an amendment drafted to do just that.

Chairman Delzer: Representative Weisz did give us an amendment that he would like us to out on. So we should amend the bill and then remove the hyperbaric oxygen program.

Representative Beadle: Motion to amend SB 2094 to remove section 6, the hyperbaric and add fluoroscopy technologists.

Representative Vigesaa: Second

Chairman Delzer: Voice Vote, All in Favor, Motion Carries

Representative J. Nelson: Motion to move SB 2094 with a Do Pass as Amended.

Representative Schmidt: Second

Chairman Delzer: Any further discussion on the amended bill before us? Seeing none we will call the roll.

A Roll Call vote was taken. Yea: 16 Nay: 0 Absent: 5

Motion Carries, Representative D. Anderson will carry the bill

Chairman Delzer: With that we will close the meeting for SB 2094.

DO 4/2/19
1 of 8

19.8055.02003
Title.04000

Prepared by the Legislative Council staff for
the House Appropriations Committee
April 1, 2019

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2094

In lieu of the amendments adopted by the House as printed on pages 1345-1347 of the House Journal, Engrossed Senate Bill No. 2094 is amended as follows:

Page 1, line 1, replace the second "and" with a comma

Page 1, line 1, after "43-17-45" insert ", and 43-62-14.1"

Page 1, line 2, after "telemedicine" insert "and the regulation of fluoroscopy technologists"

Page 1, line 2, remove the first "and"

Page 1, line 3, after "43-17-01" insert ", 43-17-02,"

Page 1, line 3, after "43-17-02.3" insert ", subsection 1 of section 43-17.1-02, and sections 43-17.1-05, 43-17.1-05.1, 43-17.1-06, and 43-62-01"

Page 1, line 4, replace the second "and" with a comma

Page 1, line 4, after the second "medicine" insert ", and the regulation of fluoroscopy technologists; to provide a penalty; and to provide for application"

Page 2, after line 8, insert:

"**SECTION 2. AMENDMENT.** Section 43-17-02 of the North Dakota Century Code is amended and reenacted as follows:

43-17-02. Persons exempt from the provisions of chapter.

The provisions of this chapter do not apply to the following:

1. Students of medicine or osteopathy who are continuing their training and performing the duties of a resident in any hospital or institution maintained and operated by the state, an agency of the federal government, or in any residency program accredited by the accreditation council on graduate medical education, provided that the North Dakota board of medicine may adopt rules relating to the licensure, fees, qualifications, activities, scope of practice, and discipline of such persons.

2. The domestic administration of family remedies.

3. Dentists practicing their profession when properly licensed.

4. Optometrists practicing their profession when properly licensed.

5. The practice of christian science or other religious tenets or religious rules or ceremonies as a form of religious worship, devotion, or healing, if the person administering, making use of, assisting in, or prescribing, such religious worship, devotion, or healing does not prescribe or administer drugs or medicines and does not perform surgical or physical operations, and if the person does not hold out to be a physician or surgeon.

6. Commissioned medical officers of the armed forces of the United States, the United States public health service, and medical officers of the veterans administration of the United States, in the discharge of their official duties, and licensed physicians from other states or territories if called in consultation with a person licensed to practice medicine in this state.

7. Doctors of chiropractic duly licensed to practice in this state pursuant to the statutes regulating such profession.

8. Podiatrists practicing their profession when properly licensed.

9. Any person rendering services as a physician assistant, if such service is rendered under the supervision, control, and responsibility of a licensed physician. However, sections 43-17-02.1 and 43-17-02.2 do apply to physician assistants. The North Dakota board of medicine shall prescribe rules governing the conduct, licensure, fees, qualifications, discipline, activities, and supervision of physician assistants. Physician assistants may not be authorized to perform any services which must be performed by persons licensed pursuant to chapters 43-12.1, 43-13, 43-15, and 43-28 or services otherwise regulated by licensing laws, notwithstanding the fact that medical doctors need not be licensed specifically to perform the services contemplated under such chapters or licensing laws.

10. A nurse practicing the nurse's profession when properly licensed by the North Dakota board of nursing.

11. ~~A person rendering fluoroscopy services as a radiologic technologist if the service is rendered under the supervision, control, and responsibility of a licensed physician and provided that the North Dakota board of medicine prescribes rules governing the conduct, permits, fees, qualifications, activities, discipline, and supervision of radiologic technologists who provide those services.~~

~~12.~~ A naturopath duly licensed to practice in this state pursuant to the statutes regulating such profession.

~~13.~~12. An individual duly licensed to practice medical imaging or radiation therapy in this state under chapter 43-62.

~~14.~~13. An acupuncturist duly licensed to practice in this state pursuant to the statutes regulating such profession."

Page 2, line 23, after "consultation" insert "on a diagnosis for a patient to a physician licensed in the state."

Page 3, line 10, replace "valid" with "bona fide"

Page 4, after line 23, insert:

"**SECTION 6. AMENDMENT.** Subsection 1 of section 43-17.1-02 of the North Dakota Century Code is amended and reenacted as follows:

1. For the purpose of investigating complaints or other information that might give rise to a disciplinary proceeding against a physician, ~~a~~ or physician

assistant~~, or a fluoroscopy technologist~~, the president of the board ~~must~~shall designate two investigative panels, each ~~comprised~~composed of six members of the board. Five members of each panel must be physician members of the board. One member of each panel must be a public member of the board.

SECTION 7. AMENDMENT. Section 43-17.1-05 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-05. Complaints.

1. Any person may make or refer written complaints to the investigative panels with reference to the acts, activities, or qualifications of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ licensed to practice in this state, or to request that an investigative panel review the qualifications of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ to continue to practice in this state. Any person ~~who~~that, in good faith, makes a report to the investigative panels under this section is not subject to civil liability for making the report. For purposes of any civil proceeding, the good faith of any person ~~who~~that makes a report pursuant to this section is presumed. Upon receipt of any complaint or request, the investigative panel shall conduct the investigation as ~~it~~the panel deems necessary to determine whether any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ has committed any of the grounds for disciplinary action provided for by law. Upon completion of ~~its~~the investigation of the investigative panel, the investigative panel shall make a finding that the investigation discloses that:

   a. There is insufficient evidence to warrant further action;

   b. The conduct of the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ does not warrant further proceedings but the investigative panel determines ~~that~~ possible errant conduct occurred that could lead to significant consequences if not corrected. In such a case, a confidential letter of concern may be sent to the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~; or

   c. The conduct of the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ indicates ~~that~~ the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ may have committed any of the grounds for disciplinary action provided for by law and which warrants further proceedings.

2. If the investigative panel determines ~~that~~ a formal hearing should be held to determine whether any licensed physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ has committed any of the grounds for disciplinary action provided for by law, ~~it~~the panel shall inform the respondent physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ involved of the specific charges to be considered by serving upon that ~~person~~individual a copy of a formal complaint filed with the board for disposition pursuant to the provisions of chapter 28-32. The board members who have served on the investigative panel may not participate in any proceeding before the board relating to ~~said~~the complaint. The complaint must be prosecuted before the board by the attorney general or one of the attorney general's assistants.

3. If an investigative panel finds ~~that~~ there are insufficient facts to warrant further investigation or action, the complaint must be dismissed and the matter is closed. The investigative panel shall provide written notice to the ~~individual or entity~~person filing the original complaint and the ~~person~~individual who is the subject of the complaint of the investigative panel's final action or recommendations, if any, concerning the complaint.

SECTION 8. AMENDMENT. Section 43-17.1-05.1 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-05.1. Reporting requirements - Penalty.

1. A physician, a physician assistant~~, or a fluoroscopy technologist~~, a health care institution in the state, a state agency, or a law enforcement agency in the state having actual knowledge that a licensed physician~~, a~~ or physician assistant~~, or a fluoroscopy technologist~~ may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board promptly shall ~~promptly~~ report that information in writing to the investigative panel of the board. A medical licensee or any institution from which the medical licensee voluntarily resigns or voluntarily limits the licensee's staff privileges shall report that licensee's action to the investigative panel of the board if that action occurs while the licensee is under formal or informal investigation by the institution or a committee of the institution for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment.

2. Upon receiving a report concerning a licensee an investigative panel shall, or on its own motion an investigative panel may, investigate any evidence that appears to show a licensee is or may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board.

3. A person required to report under this section ~~who~~that makes a report in good faith is not subject to criminal prosecution or civil liability for making the report. For purposes of any civil proceeding, the good faith of any person ~~who~~that makes a report pursuant to this section is presumed. A physician who obtains information in the course of a physician-patient relationship in which the patient is another physician is not required to report if the treating physician successfully counsels the other physician to limit or withdraw from practice to the extent required by the impairment. A physician who obtains information in the course of a professional peer review pursuant to chapter 23-34 is not required to report pursuant to this section. A physician who does not report information obtained in a professional peer review is not subject to criminal prosecution or civil liability for not making a report. For purposes of this section, a person has actual knowledge if that person acquired the information by personal observation or under circumstances that cause that person to believe there exists a substantial likelihood that the information is correct.

4. An agency or health care institution that violates this section is guilty of a class B misdemeanor. A physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ who violates this section is subject to administrative action by the board as specified by law or by administrative rule.

SECTION 9. AMENDMENT. Section 43-17.1-06 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-06. Powers of the board's investigative panels.

The board's investigative panels may:

1. Subpoena witnesses and physician and hospital records relating to the practice of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ under investigation. The confidentiality of the records by any other statute or law does not affect the validity of an investigative panel's subpoena nor the admissibility of the records in board proceedings; however, the proceedings and records of a committee ~~that~~which are exempt from subpoena, discovery, or introduction into evidence under chapter 23-34 are not subject to this subsection.

2. Hold preliminary hearings.

3. Upon probable cause, require any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ under investigation to submit to a physical, psychiatric, or competency examination or chemical dependency evaluation.

4. Appoint special masters to conduct preliminary hearings.

5. Employ independent investigators ~~when~~if necessary.

6. Hold confidential conferences with any complainant or any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ with respect to any complaint.

7. File a formal complaint against any licensed physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ with the board.

SECTION 10. AMENDMENT. Section 43-62-01 of the North Dakota Century Code is amended and reenacted as follows:

43-62-01. Definitions.

As used in this chapter:

1. "Board" means the North Dakota medical imaging and radiation therapy board.

2. "Certification organization" means a national certification organization that specializes in the certification and registration of medical imaging and radiation therapy technical personnel and which has programs accredited by the national commission for certifying agencies, American national standards institute or the international organization for standardization, or other accreditation organization recognized by the board.

3. "Licensed practitioner" means a licensed physician, advanced practice registered nurse, chiropractor, dentist, or podiatrist.

4. "Licensee" means an individual licensed by the board to perform medical imaging or radiation therapy and operate medical imaging or radiation therapy equipment, including a nuclear medicine technologist, radiation therapist, radiographer, radiologist assistant, sonographer, fluoroscopy technologist, or magnetic resonance imaging technologist.

5. "Medical imaging" means the performance of any diagnostic or interventional procedure or operation of medical imaging equipment intended for use in the diagnosis or visualization of disease or other medical conditions in human beings, including magnetic resonance imaging, fluoroscopy, nuclear medicine, sonography, or x-rays.

6. "Medical physicist" means an individual who is certified by the American board of radiology, American board of medical physics, American board of science in nuclear medicine, or Canadian college of physics in medicine in radiological physics or one of the subspecialties of radiological physics.

7. "Primary modality" means an individual practicing as a nuclear medicine technologist, radiation therapist, radiographer, radiologist assistant, sonographer, fluoroscopy technologist, or magnetic resonance imaging technologist.

8. "Protected health information" has the same meaning as provided under section 23-01.3-01.

9. "Radiation therapy" means the performance of any procedure or operation of radiation therapy equipment intended for use in the treatment of disease or other medical conditions in human beings.

10. "Radiation therapist" means an individual, other than a licensed practitioner or authorized user, who performs procedures and applies ionizing radiation emitted from x-ray machines, particle accelerators, or sealed radioactive sources to human beings for therapeutic purposes.

(Contingent effective date - See note) Definitions.

As used in this chapter:

1. "Board" means the North Dakota medical imaging and radiation therapy board.

2. "Certification organization" means a national certification organization that specializes in the certification and registration of medical imaging and radiation therapy technical personnel and which has programs accredited by the national commission for certifying agencies, American national standards institute or the international organization for standardization, or other accreditation organization recognized by the board.

3. "Licensed practitioner" means a licensed physician, advanced practice registered nurse, chiropractor, dentist, or podiatrist.

4. "Licensee" means an individual licensed by the board to perform medical imaging or radiation therapy and operate medical imaging or radiation therapy equipment, including a nuclear medicine technologist, radiation

therapist, radiographer, radiologist assistant, x-ray operator, sonographer, fluoroscopy technologist, or magnetic resonance imaging technologist.

5. "Medical imaging" means the performance of any diagnostic or interventional procedure or operation of medical imaging equipment intended for use in the diagnosis or visualization of disease or other medical conditions in human beings, including magnetic resonance imaging, fluoroscopy, nuclear medicine, sonography, or x-rays.

6. "Medical physicist" means an individual who is certified by the American board of radiology, American board of medical physics, American board of science in nuclear medicine, or Canadian college of physics in medicine in radiological physics or one of the subspecialties of radiological physics.

7. "Primary modality" means an individual practicing as a nuclear medicine technologist, radiation therapist, radiographer, radiologist assistant, sonographer, fluoroscopy technologist, or magnetic resonance imaging technologist.

8. "Protected health information" has the same meaning as provided under section 23-01.3-01.

9. "Radiation therapy" means the performance of any procedure or operation of radiation therapy equipment intended for use in the treatment of disease or other medical conditions in human beings.

10. "Radiation therapist" means an individual, other than a licensed practitioner or authorized user, who performs procedures and applies ionizing radiation emitted from x-ray machines, particle accelerators, or sealed radioactive sources to human beings for therapeutic purposes.

SECTION 11. Section 43-62-14.1 of the North Dakota Century Code is created and enacted as follows:

43-62-14.1. Fluoroscopy technologist.

1. Effective August 1, 2019, an individual licensed or permitted as a fluoroscopy technologist by the North Dakota board of medicine who is in good standing on that date, automatically becomes licensed as a fluoroscopy technologist by the North Dakota medical imaging and radiation therapy board.

   a. Effective August 1, 2019, the North Dakota board of medicine shall revoke every active fluoroscopy technologists license issued by that board.

   b. Effective August 1, 2019, the North Dakota medical imaging and radiation therapy board shall issue a fluoroscopy technologist license to every individual qualified under this subsection to be automatically licensed.

2. The scope of practice of a licensed fluoroscopy technologist is limited to gastrointestinal fluoroscopy of the esophagus, stomach, and small and large intestines.

DP 4/2/14
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3. Fluoroscopy services provided by a licensed fluoroscopy technologist must be provided under the supervision of a primary supervising physician.

4. If a fluoroscopy technologist performs a fluoroscopy procedure outside the presence of the technologist's primary supervising physician, the technologist must be supervised by an onsite supervising physician who is immediately available to the technologist for consultation and supervision at all times the technologist is performing a fluoroscopy procedure.

5. Under this section, a supervising physician may not designate the fluoroscopy technologist to take over the physician's duties or cover the physician's practice. During an absence or temporary disability of a primary supervising physician, the fluoroscopy technologist is responsible to the substitute primary supervising physician.

6. To qualify for biennial license renewal, a fluoroscopy technologist shall submit to the board:

   a. Evidence of completion of at least six hours of continuing education on safety and relevant radiation protection; and

   b. A copy of an agreement with a primary supervising physician.

SECTION 12. APPLICATION. To facilitate application of sections 2 and 6 through 11 of this Act, the North Dakota board of medicine shall provide the North Dakota medical imaging and radiation therapy board with the files regarding all active fluoroscopy technologists licensed by the North Dakota board of medicine necessary for the North Dakota medical imaging and radiation therapy board to take over licensure and regulation of these technologists."

Renumber accordingly

Date: 4/1/2019
Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2094

House Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: **Remove section 6 and Add Fluoroscopist technologist**

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By **Representative Beadle** Seconded By **Representative Vigesaa**

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer					
Representative Kempenich					
Representative Anderson			Representative Schobinger		
Representative Beadle			Representative Vigesaa		
Representative Bellew					
Representative Brandenburg					
Representative Howe			Representative Boe		
Representative Kreidt			Representative Holman		
Representative Martinson			Representative Mock		
Representative Meier					
Representative Monson					
Representative Nathe					
Representative J. Nelson					
Representative Sanford					
Representative Schatz					
Representative Schmidt					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

Voice Vote/Motion Carries

Date: 4/1/2019
Roll Call Vote #: 2

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2094

House Appropriations Committee

☐ Subcommittee

Amendment LC# or Description:

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐

Motion Made By **Representative J. Nelson** Seconded By **Representative Schmidt**

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer	X				
Representative Kempenich	A				
Representative Anderson	X		Representative Schobinger	X	
Representative Beadle	X		Representative Vigesaa	X	
Representative Bellew	A				
Representative Brandenburg	X				
Representative Howe	X		Representative Boe	X	X
Representative Kreidt	A		Representative Holman	A	
Representative Martinson	X		Representative Mock	X	
Representative Meier	X				
Representative Monson	A				
Representative Nathe	X				
Representative J. Nelson	X				
Representative Sanford	X				
Representative Schatz	X				
Representative Schmidt	X				

Total (Yes) 16 No 0

Absent 5

Floor Assignment **Representative D. Anderson**

Motion Carries

REPORT OF STANDING COMMITTEE

SB 2094, as engrossed and amended: Appropriations Committee (Rep. Delzer, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (16 YEAS, 0 NAYS, 5 ABSENT AND NOT VOTING). Engrossed SB 2094, as amended, was placed on the Sixth order on the calendar.

In lieu of the amendments adopted by the House as printed on pages 1345-1347 of the House Journal, Engrossed Senate Bill No. 2094 is amended as follows:

Page 1, line 1, replace the second "and" with a comma

Page 1, line 1, after "43-17-45" insert ", and 43-62-14.1"

Page 1, line 2, after "telemedicine" insert "and the regulation of fluoroscopy technologists"

Page 1, line 2, remove the first "and"

Page 1, line 3, after "43-17-01" insert ", 43-17-02,"

Page 1, line 3, after "43-17-02.3" insert ", subsection 1 of section 43-17.1-02, and sections 43-17.1-05, 43-17.1-05.1, 43-17.1-06, and 43-62-01"

Page 1, line 4, replace the second "and" with a comma

Page 1, line 4, after the second "medicine" insert ", and the regulation of fluoroscopy technologists; to provide a penalty; and to provide for application"

Page 2, after line 8, insert:

"**SECTION 2. AMENDMENT.** Section 43-17-02 of the North Dakota Century Code is amended and reenacted as follows:

43-17-02. Persons exempt from the provisions of chapter.

The provisions of this chapter do not apply to the following:

1. Students of medicine or osteopathy who are continuing their training and performing the duties of a resident in any hospital or institution maintained and operated by the state, an agency of the federal government, or in any residency program accredited by the accreditation council on graduate medical education, provided that the North Dakota board of medicine may adopt rules relating to the licensure, fees, qualifications, activities, scope of practice, and discipline of such persons.

2. The domestic administration of family remedies.

3. Dentists practicing their profession when properly licensed.

4. Optometrists practicing their profession when properly licensed.

5. The practice of christian science or other religious tenets or religious rules or ceremonies as a form of religious worship, devotion, or healing, if the person administering, making use of, assisting in, or prescribing, such religious worship, devotion, or healing does not prescribe or administer drugs or medicines and does not perform surgical or physical operations, and if the person does not hold out to be a physician or surgeon.

6. Commissioned medical officers of the armed forces of the United States, the United States public health service, and medical officers of the

veterans administration of the United States, in the discharge of their official duties, and licensed physicians from other states or territories if called in consultation with a person licensed to practice medicine in this state.

7. Doctors of chiropractic duly licensed to practice in this state pursuant to the statutes regulating such profession.

8. Podiatrists practicing their profession when properly licensed.

9. Any person rendering services as a physician assistant, if such service is rendered under the supervision, control, and responsibility of a licensed physician. However, sections 43-17-02.1 and 43-17-02.2 do apply to physician assistants. The North Dakota board of medicine shall prescribe rules governing the conduct, licensure, fees, qualifications, discipline, activities, and supervision of physician assistants. Physician assistants may not be authorized to perform any services which must be performed by persons licensed pursuant to chapters 43-12.1, 43-13, 43-15, and 43-28 or services otherwise regulated by licensing laws, notwithstanding the fact that medical doctors need not be licensed specifically to perform the services contemplated under such chapters or licensing laws.

10. A nurse practicing the nurse's profession when properly licensed by the North Dakota board of nursing.

11. ~~A person rendering fluoroscopy services as a radiologic technologist if the service is rendered under the supervision, control, and responsibility of a licensed physician and provided that the North Dakota board of medicine prescribes rules governing the conduct, permits, fees, qualifications, activities, discipline, and supervision of radiologic technologists who provide those services.~~

~~12.~~ A naturopath duly licensed to practice in this state pursuant to the statutes regulating such profession.

~~13.~~12. An individual duly licensed to practice medical imaging or radiation therapy in this state under chapter 43-62.

~~14.~~13. An acupuncturist duly licensed to practice in this state pursuant to the statutes regulating such profession."

Page 2, line 23, after "consultation" insert "on a diagnosis for a patient to a physician licensed in the state,"

Page 3, line 10, replace "valid" with "bona fide"

Page 4, after line 23, insert:

"**SECTION 6. AMENDMENT.** Subsection 1 of section 43-17.1-02 of the North Dakota Century Code is amended and reenacted as follows:

1. For the purpose of investigating complaints or other information that might give rise to a disciplinary proceeding against a physician~~, a~~ or physician assistant~~, or a fluoroscopy technologist~~, the president of the board ~~must~~shall designate two investigative panels, each ~~comprised~~composed of six members of the board. Five members of each panel must be physician members of the board. One member of each panel must be a public member of the board.

SECTION 7. AMENDMENT. Section 43-17.1-05 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-05. Complaints.

1. Any person may make or refer written complaints to the investigative panels with reference to the acts, activities, or qualifications of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ licensed to practice in this state, or to request that an investigative panel review the qualifications of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ to continue to practice in this state. Any person ~~who~~that, in good faith, makes a report to the investigative panels under this section is not subject to civil liability for making the report. For purposes of any civil proceeding, the good faith of any person ~~who~~that makes a report pursuant to this section is presumed. Upon receipt of any complaint or request, the investigative panel shall conduct the investigation as ~~it~~the panel deems necessary to determine whether any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ has committed any of the grounds for disciplinary action provided for by law. Upon completion of ~~its~~the investigation of the investigative panel, the investigative panel shall make a finding that the investigation discloses that:

   a. There is insufficient evidence to warrant further action;

   b. The conduct of the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ does not warrant further proceedings but the investigative panel determines ~~that~~ possible errant conduct occurred that could lead to significant consequences if not corrected. In such a case, a confidential letter of concern may be sent to the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~; or

   c. The conduct of the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ indicates ~~that~~ the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ may have committed any of the grounds for disciplinary action provided for by law and which warrants further proceedings.

2. If the investigative panel determines ~~that~~ a formal hearing should be held to determine whether any licensed physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ has committed any of the grounds for disciplinary action provided for by law, ~~it~~the panel shall inform the respondent physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ involved of the specific charges to be considered by serving upon that ~~person~~individual a copy of a formal complaint filed with the board for disposition pursuant to the provisions of chapter 28-32. The board members who have served on the investigative panel may not participate in any proceeding before the board relating to ~~said~~the complaint. The complaint must be prosecuted before the board by the attorney general or one of the attorney general's assistants.

3. If an investigative panel finds ~~that~~ there are insufficient facts to warrant further investigation or action, the complaint must be dismissed and the matter is closed. The investigative panel shall provide written notice to the ~~individual or entity~~person filing the original complaint and the ~~person~~individual who is the subject of the complaint of the investigative panel's final action or recommendations, if any, concerning the complaint.

SECTION 8. AMENDMENT. Section 43-17.1-05.1 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-05.1. Reporting requirements - Penalty.

1. A physician, a physician assistant~~, or a fluoroscopy technologist~~, a health care institution in the state, a state agency, or a law enforcement agency

in the state having actual knowledge that a licensed physician~~, a~~ or physician assistant~~, or a fluoroscopy technologist~~ may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board promptly shall ~~promptly~~ report that information in writing to the investigative panel of the board. A medical licensee or any institution from which the medical licensee voluntarily resigns or voluntarily limits the licensee's staff privileges shall report that licensee's action to the investigative panel of the board if that action occurs while the licensee is under formal or informal investigation by the institution or a committee of the institution for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment.

2. Upon receiving a report concerning a licensee an investigative panel shall, or on its own motion an investigative panel may, investigate any evidence that appears to show a licensee is or may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board.

3. A person required to report under this section ~~who~~that makes a report in good faith is not subject to criminal prosecution or civil liability for making the report. For purposes of any civil proceeding, the good faith of any person ~~who~~that makes a report pursuant to this section is presumed. A physician who obtains information in the course of a physician-patient relationship in which the patient is another physician is not required to report if the treating physician successfully counsels the other physician to limit or withdraw from practice to the extent required by the impairment. A physician who obtains information in the course of a professional peer review pursuant to chapter 23-34 is not required to report pursuant to this section. A physician who does not report information obtained in a professional peer review is not subject to criminal prosecution or civil liability for not making a report. For purposes of this section, a person has actual knowledge if that person acquired the information by personal observation or under circumstances that cause that person to believe there exists a substantial likelihood that the information is correct.

4. An agency or health care institution that violates this section is guilty of a class B misdemeanor. A physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ who violates this section is subject to administrative action by the board as specified by law or by administrative rule.

SECTION 9. AMENDMENT. Section 43-17.1-06 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-06. Powers of the board's investigative panels.

The board's investigative panels may:

1. Subpoena witnesses and physician and hospital records relating to the practice of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ under investigation. The confidentiality of the records by any other statute or law does not affect the validity of an investigative panel's subpoena nor the admissibility of the records in board proceedings; however, the proceedings and records of a committee ~~that~~which are exempt from subpoena, discovery, or introduction into evidence under chapter 23-34 are not subject to this subsection.

2. Hold preliminary hearings.

3. Upon probable cause, require any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ under investigation to submit to a physical,

psychiatric, or competency examination or chemical dependency evaluation.

4. Appoint special masters to conduct preliminary hearings.

5. Employ independent investigators ~~when~~if necessary.

6. Hold confidential conferences with any complainant or any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ with respect to any complaint.

7. File a formal complaint against any licensed physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ with the board.

SECTION 10. AMENDMENT. Section 43-62-01 of the North Dakota Century Code is amended and reenacted as follows:

43-62-01. Definitions.

As used in this chapter:

1. "Board" means the North Dakota medical imaging and radiation therapy board.

2. "Certification organization" means a national certification organization that specializes in the certification and registration of medical imaging and radiation therapy technical personnel and which has programs accredited by the national commission for certifying agencies, American national standards institute or the international organization for standardization, or other accreditation organization recognized by the board.

3. "Licensed practitioner" means a licensed physician, advanced practice registered nurse, chiropractor, dentist, or podiatrist.

4. "Licensee" means an individual licensed by the board to perform medical imaging or radiation therapy and operate medical imaging or radiation therapy equipment, including a nuclear medicine technologist, radiation therapist, radiographer, radiologist assistant, sonographer, fluoroscopy technologist, or magnetic resonance imaging technologist.

5. "Medical imaging" means the performance of any diagnostic or interventional procedure or operation of medical imaging equipment intended for use in the diagnosis or visualization of disease or other medical conditions in human beings, including magnetic resonance imaging, fluoroscopy, nuclear medicine, sonography, or x-rays.

6. "Medical physicist" means an individual who is certified by the American board of radiology, American board of medical physics, American board of science in nuclear medicine, or Canadian college of physics in medicine in radiological physics or one of the subspecialties of radiological physics.

7. "Primary modality" means an individual practicing as a nuclear medicine technologist, radiation therapist, radiographer, radiologist assistant, sonographer, fluoroscopy technologist, or magnetic resonance imaging technologist.

8. "Protected health information" has the same meaning as provided under section 23-01.3-01.

9. "Radiation therapy" means the performance of any procedure or operation of radiation therapy equipment intended for use in the treatment of disease or other medical conditions in human beings.

10. "Radiation therapist" means an individual, other than a licensed practitioner or authorized user, who performs procedures and applies ionizing radiation emitted from x-ray machines, particle accelerators, or sealed radioactive sources to human beings for therapeutic purposes.

(Contingent effective date - See note) Definitions.

As used in this chapter:

1. "Board" means the North Dakota medical imaging and radiation therapy board.

2. "Certification organization" means a national certification organization that specializes in the certification and registration of medical imaging and radiation therapy technical personnel and which has programs accredited by the national commission for certifying agencies, American national standards institute or the international organization for standardization, or other accreditation organization recognized by the board.

3. "Licensed practitioner" means a licensed physician, advanced practice registered nurse, chiropractor, dentist, or podiatrist.

4. "Licensee" means an individual licensed by the board to perform medical imaging or radiation therapy and operate medical imaging or radiation therapy equipment, including a nuclear medicine technologist, radiation therapist, radiographer, radiologist assistant, x-ray operator, sonographer, fluoroscopy technologist, or magnetic resonance imaging technologist.

5. "Medical imaging" means the performance of any diagnostic or interventional procedure or operation of medical imaging equipment intended for use in the diagnosis or visualization of disease or other medical conditions in human beings, including magnetic resonance imaging, fluoroscopy, nuclear medicine, sonography, or x-rays.

6. "Medical physicist" means an individual who is certified by the American board of radiology, American board of medical physics, American board of science in nuclear medicine, or Canadian college of physics in medicine in radiological physics or one of the subspecialties of radiological physics.

7. "Primary modality" means an individual practicing as a nuclear medicine technologist, radiation therapist, radiographer, radiologist assistant, sonographer, fluoroscopy technologist, or magnetic resonance imaging technologist.

8. "Protected health information" has the same meaning as provided under section 23-01.3-01.

9. "Radiation therapy" means the performance of any procedure or operation of radiation therapy equipment intended for use in the treatment of disease or other medical conditions in human beings.

10. "Radiation therapist" means an individual, other than a licensed practitioner or authorized user, who performs procedures and applies ionizing radiation emitted from x-ray machines, particle accelerators, or sealed radioactive sources to human beings for therapeutic purposes.

SECTION 11. Section 43-62-14.1 of the North Dakota Century Code is created and enacted as follows:

43-62-14.1. Fluoroscopy technologist.

1. Effective August 1, 2019, an individual licensed or permitted as a fluoroscopy technologist by the North Dakota board of medicine who is in good standing on that date, automatically becomes licensed as a fluoroscopy technologist by the North Dakota medical imaging and radiation therapy board.

   a. Effective August 1, 2019, the North Dakota board of medicine shall revoke every active fluoroscopy technologists license issued by that board.

   b. Effective August 1, 2019, the North Dakota medical imaging and radiation therapy board shall issue a fluoroscopy technologist license to every individual qualified under this subsection to be automatically licensed.

2. The scope of practice of a licensed fluoroscopy technologist is limited to gastrointestinal fluoroscopy of the esophagus, stomach, and small and large intestines.

3. Fluoroscopy services provided by a licensed fluoroscopy technologist must be provided under the supervision of a primary supervising physician.

4. If a fluoroscopy technologist performs a fluoroscopy procedure outside the presence of the technologist's primary supervising physician, the technologist must be supervised by an onsite supervising physician who is immediately available to the technologist for consultation and supervision at all times the technologist is performing a fluoroscopy procedure.

5. Under this section, a supervising physician may not designate the fluoroscopy technologist to take over the physician's duties or cover the physician's practice. During an absence or temporary disability of a primary supervising physician, the fluoroscopy technologist is responsible to the substitute primary supervising physician.

6. To qualify for biennial license renewal, a fluoroscopy technologist shall submit to the board:

   a. Evidence of completion of at least six hours of continuing education on safety and relevant radiation protection; and

   b. A copy of an agreement with a primary supervising physician.

SECTION 12. APPLICATION. To facilitate application of sections 2 and 6 through 11 of this Act, the North Dakota board of medicine shall provide the North Dakota medical imaging and radiation therapy board with the files regarding all active fluoroscopy technologists licensed by the North Dakota board of medicine necessary for the North Dakota medical imaging and radiation therapy board to take over licensure and regulation of these technologists."

Renumber accordingly

2019 CONFERENCE COMMITTEE

SB 2094

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2094
4/15/2019
Job # 34746

☐ Subcommittee
☒ Conference Committee

Committee Clerk: Justin Velez

Explanation or reason for introduction of bill/resolution:

Relating to the definitions of the practice of medicine and telemedicine and the practice of medicine.

Minutes: Attachment #1

Madam Chair Lee opens the conference committee on SB 2094. Please see Attachment #1 for proposed amendment 19.8055.02004

Madam Chair Lee: As you all know this was the bill which removed the regulation of the fluoroscopy technologists from the board under which they were operating and moving them out. We do have some changes that need to be made to clean it up and so that is what the amendments are for.

(00:50) Allyson Hicks, Assistant Attorney General and General Counsel for the North Dakota Medical Imaging and Radiation Therapy Board: Essentially, we added the majority of the information in section 10 of the amendment that is beginning on page 5. 43-62 is the Medical Imaging Radiation and Therapy Board chapter so, those are the changes we made and essentially what this did was, it took the majority of the regulations governing the fluoroscopy techs out of the Board of Medicine administrative rules and put them into our statue so that there were some rules of the game for this one individual. It just indicates when they are licensed it will automatically be grandfathered in, their scope of practice, that they must be supervised by a primary supervising physician and more information about substitute supervising positions and biennial license renewal and continuing education. I did work with Jennifer Clark at Legislative Council in regards to some of the language in the amendment that was lost in translation. That appears to be in amendment .02004 that a lot of that did get fixed up. The only thing I would note for the committee is, in speaking with the Medical Board Director Bonnie Storbakken about this, in page 12, lines 22-23, that provides for revocation of the fluoroscopy techs license under the Board of Medicine. Revocation and administrative boards have a very specific connotation; it is a disciplinary action. My understanding is the governing bodies intended for it to just expire so that the Medical Imaging Board would but, the way that it is written now, that would be a disciplinary proceeding under the Board of Medicine, this would go on their disciplinary record and be reported to the Medical Imaging board. I don think those are intended consequences.

Madam Chair Lee: Can you please tell me where that would be?

Allyson Hicks: That would be page 12, line 22-23 of .02003 version.

Madam Chair Lee: Do you have corrective language that we might be able to hear?

Allyson Hicks: I would suggest just the Board of Medicine shall expire or shall not renew, either of those work and they serve the function that you were hoping for so, I would leave that to the discretion of the committee.

Madam Chair Lee: Does one mean something different from the other?

Allyson Hicks: Expire means that it just discontinues and not renews means it is being taken over by a different board.

Madam Chair Lee: Any questions for Mrs. Hicks? If not, thank you. House member would you have any concern about permit to expire or shall not renew.

Representative Rohr: Everybody seems accepting of that.

Representative Porter: The only thing I would add is that since the transition is taking place on both dates, if we set it not to renew it would still be an active license through the end of the year so I think that should expire. Sub A should expire because sub B is taking over on that same date. You wouldn't want it to be going forward, you would want it to end on the same day as the other one starts.

Madam Chair Lee: Okay, so permit to expire would seem like the better option.

Representative Porter: It would to me.

Madam Chair Lee: That makes sense. Any comments from any committee members about that particular choice of language in that spot? I should ask Mrs. Hicks also, is there any other place that you see a concern?

Allyson Hicks: I believe that amendment .02004 has everything that the Medical Imaging and Radiation Therapy Board needs.

Madam Chair Lee: Perfect, thank you. Any further questions for Mrs. Hicks? If not, thank you. Mrs. Storbakken did you have a comment?

(06:52) Bonnie Storbakken, Executive Secretary of the North Dakota Board of Medicine: I do not have any comments at this time.

Madam Chair Lee: So, these are acceptable to you with the current amendment?

Bonnie Storbakken: Yes, I appreciate you entertaining the expiration rather than the revoking.

Madam Chair Lee: Thank you for catching that. Any other questions from any members of the committee? Any questions from anyone in the gallery? If not, is there a motion?

Representative Porter: I move that the **HOUSE RECEDE** from its amendments and **FURTHER AMEND** version .02004, with the change that has been spoken of on page 5, in section 10, sub A, second line, instead of the word "revoke" insert the word "expire".
Seconded by Senator O. Larsen

Madam Chair Lee: Is there any discussion on the motion that we would replace the word "revoke" with "expire"?

(08:30-09:20) Courtney Koebele, Executive Director of the North Dakota Medical Association, wanted to make sure that the amendment the house adopted on page 2, line 23, after "consultation" insert "on a diagnosis for a patient to a physician licensed in the state" would still be added with the committees .02004 amendments. Representative Porter explained to Mrs. Koebele that all of the original house amendments are still in SB 2094.

Madam Chair Lee: Any further discussion from the committee? If not, we will vote on the amendment that the house recede from the amendment and further amend to eliminate "revoke" and include instead "expire". Please call the roll.

ROLL CALL VOTE TAKEN

SENATORS: 3 YEA, 0 NAY, 0 ABSENT
REPRESENTATIVES: 3 YEA, 0 NAY, 0 ABSENT
FINAL VOTE: 6 YEA, 0 NAY, 0 ABSENT

Senator J. Lee and Representative Rohr will carry SB 2094 to the floor in their respective chambers.

Madam Chair Lee closes the conference committee on SB 2094.

SK
4/15
1 of 4

19.8055.02005
Title.05000

Adopted by the Conference Committee

April 15, 2019

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2094

That the House recede from its amendments as printed on pages 1263-1269 of the Senate Journal and pages 1466-1472 of the House Journal and that Engrossed Senate Bill No. 2094 be amended as follows:

Page 1, line 1, replace the second "and" with a comma

Page 1, line 1, after "43-17-45" insert ", and 43-62-14.1"

Page 1, line 2, after "telemedicine" insert "and the regulation of fluoroscopy technologists"

Page 1, line 2, remove the first "and"

Page 1, line 3, after "43-17-01" insert ", 43-17-02,"

Page 1, line 3, after "43-17-02.3" insert ", subsection 1 of section 43-17.1-02, and sections 43-17.1-05, 43-17.1-05.1, and 43-17.1-06"

Page 1, line 4, replace the second "and" with a comma

Page 1, line 4, after the second "medicine" insert ", and the regulation of fluoroscopy technologists; to provide a penalty; and to provide for application"

Page 2, after line 8, insert:

"**SECTION 2. AMENDMENT.** Section 43-17-02 of the North Dakota Century Code is amended and reenacted as follows:

43-17-02. Persons exempt from the provisions of chapter.

The provisions of this chapter do not apply to the following:

1. Students of medicine or osteopathy who are continuing their training and performing the duties of a resident in any hospital or institution maintained and operated by the state, an agency of the federal government, or in any residency program accredited by the accreditation council on graduate medical education, provided that the North Dakota board of medicine may adopt rules relating to the licensure, fees, qualifications, activities, scope of practice, and discipline of such persons.

2. The domestic administration of family remedies.

3. Dentists practicing their profession when properly licensed.

4. Optometrists practicing their profession when properly licensed.

5. The practice of christian science or other religious tenets or religious rules or ceremonies as a form of religious worship, devotion, or healing, if the person administering, making use of, assisting in, or prescribing, such religious worship, devotion, or healing does not prescribe or administer drugs or medicines and does not perform surgical or physical operations, and if the person does not hold out to be a physician or surgeon.

6. Commissioned medical officers of the armed forces of the United States, the United States public health service, and medical officers of the veterans administration of the United States, in the discharge of their official duties, and licensed physicians from other states or territories if called in consultation with a person licensed to practice medicine in this state.

7. Doctors of chiropractic duly licensed to practice in this state pursuant to the statutes regulating such profession.

8. Podiatrists practicing their profession when properly licensed.

9. Any person rendering services as a physician assistant, if such service is rendered under the supervision, control, and responsibility of a licensed physician. However, sections 43-17-02.1 and 43-17-02.2 do apply to physician assistants. The North Dakota board of medicine shall prescribe rules governing the conduct, licensure, fees, qualifications, discipline, activities, and supervision of physician assistants. Physician assistants may not be authorized to perform any services which must be performed by persons licensed pursuant to chapters 43-12.1, 43-13, 43-15, and 43-28 or services otherwise regulated by licensing laws, notwithstanding the fact that medical doctors need not be licensed specifically to perform the services contemplated under such chapters or licensing laws.

10. A nurse practicing the nurse's profession when properly licensed by the North Dakota board of nursing.

11. ~~A person rendering fluoroscopy services as a radiologic technologist if the service is rendered under the supervision, control, and responsibility of a licensed physician and provided that the North Dakota board of medicine prescribes rules governing the conduct, permits, fees, qualifications, activities, discipline, and supervision of radiologic technologists who provide those services.~~

~~12.~~ A naturopath duly licensed to practice in this state pursuant to the statutes regulating such profession.

~~13.~~12. An individual duly licensed to practice medical imaging or radiation therapy in this state under chapter 43-62.

~~14.~~13. An acupuncturist duly licensed to practice in this state pursuant to the statutes regulating such profession."

Page 2, line 23, after "consultation" insert "on a diagnosis for a patient to a physician licensed in the state,"

Page 3, line 10, replace "valid" with "bona fide"

Page 4, after line 23, insert:

"**SECTION 6. AMENDMENT.** Subsection 1 of section 43-17.1-02 of the North Dakota Century Code is amended and reenacted as follows:

1. For the purpose of investigating complaints or other information that might give rise to a disciplinary proceeding against a physician~~, a~~ or physician

assistant~~, or a fluoroscopy technologist~~, the president of the board ~~must~~shall designate two investigative panels, each ~~comprised~~composed of six members of the board. Five members of each panel must be physician members of the board. One member of each panel must be a public member of the board.

SECTION 7. AMENDMENT. Section 43-17.1-05 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-05. Complaints.

1. Any person may make or refer written complaints to the investigative panels with reference to the acts, activities, or qualifications of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ licensed to practice in this state, or to request that an investigative panel review the qualifications of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ to continue to practice in this state. Any person ~~who~~that, in good faith, makes a report to the investigative panels under this section is not subject to civil liability for making the report. For purposes of any civil proceeding, the good faith of any person ~~who~~that makes a report pursuant to this section is presumed. Upon receipt of any complaint or request, the investigative panel shall conduct the investigation as ~~it~~the panel deems necessary to determine whether any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ has committed any of the grounds for disciplinary action provided for by law. Upon completion of ~~its~~the investigation of the investigative panel, the investigative panel shall make a finding that the investigation discloses that:

   a. There is insufficient evidence to warrant further action;

   b. The conduct of the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ does not warrant further proceedings but the investigative panel determines ~~that~~ possible errant conduct occurred that could lead to significant consequences if not corrected. In such a case, a confidential letter of concern may be sent to the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~; or

   c. The conduct of the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ indicates ~~that~~ the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ may have committed any of the grounds for disciplinary action provided for by law and which warrants further proceedings.

2. If the investigative panel determines ~~that~~ a formal hearing should be held to determine whether any licensed physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ has committed any of the grounds for disciplinary action provided for by law, ~~it~~the panel shall inform the respondent physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ involved of the specific charges to be considered by serving upon that ~~person~~individual a copy of a formal complaint filed with the board for disposition pursuant to the provisions of chapter 28-32. The board members who have served on the investigative panel may not participate in any proceeding before the board relating to ~~said~~the complaint. The complaint must be prosecuted before the board by the attorney general or one of the attorney general's assistants.

3. If an investigative panel finds ~~that~~ there are insufficient facts to warrant further investigation or action, the complaint must be dismissed and the matter is closed. The investigative panel shall provide written notice to the ~~individual or entity~~person filing the original complaint and the ~~person~~individual who is the subject of the complaint of the investigative panel's final action or recommendations, if any, concerning the complaint.

SECTION 8. AMENDMENT. Section 43-17.1-05.1 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-05.1. Reporting requirements - Penalty.

1. A physician, a physician assistant~~, or a fluoroscopy technologist~~, a health care institution in the state, a state agency, or a law enforcement agency in the state having actual knowledge that a licensed physician~~, a~~ or physician assistant~~, or a fluoroscopy technologist~~ may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board promptly shall ~~promptly~~ report that information in writing to the investigative panel of the board. A medical licensee or any institution from which the medical licensee voluntarily resigns or voluntarily limits the licensee's staff privileges shall report that licensee's action to the investigative panel of the board if that action occurs while the licensee is under formal or informal investigation by the institution or a committee of the institution for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment.

2. Upon receiving a report concerning a licensee an investigative panel shall, or on its own motion an investigative panel may, investigate any evidence that appears to show a licensee is or may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board.

3. A person required to report under this section ~~who~~that makes a report in good faith is not subject to criminal prosecution or civil liability for making the report. For purposes of any civil proceeding, the good faith of any person ~~who~~that makes a report pursuant to this section is presumed. A physician who obtains information in the course of a physician-patient relationship in which the patient is another physician is not required to report if the treating physician successfully counsels the other physician to limit or withdraw from practice to the extent required by the impairment. A physician who obtains information in the course of a professional peer review pursuant to chapter 23-34 is not required to report pursuant to this section. A physician who does not report information obtained in a professional peer review is not subject to criminal prosecution or civil liability for not making a report. For purposes of this section, a person has actual knowledge if that person acquired the information by personal observation or under circumstances that cause that person to believe there exists a substantial likelihood that the information is correct.

4. An agency or health care institution that violates this section is guilty of a class B misdemeanor. A physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ who violates this section is subject to administrative action by the board as specified by law or by administrative rule.

SECTION 9. AMENDMENT. Section 43-17.1-06 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-06. Powers of the board's investigative panels.

The board's investigative panels may:

1. Subpoena witnesses and physician and hospital records relating to the practice of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ under investigation. The confidentiality of the records by any other statute or law does not affect the validity of an investigative panel's subpoena nor the admissibility of the records in board proceedings; however, the proceedings and records of a committee ~~that~~which are exempt from subpoena, discovery, or introduction into evidence under chapter 23-34 are not subject to this subsection.

2. Hold preliminary hearings.

3. Upon probable cause, require any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ under investigation to submit to a physical, psychiatric, or competency examination or chemical dependency evaluation.

4. Appoint special masters to conduct preliminary hearings.

5. Employ independent investigators ~~when~~if necessary.

6. Hold confidential conferences with any complainant or any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ with respect to any complaint.

7. File a formal complaint against any licensed physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ with the board.

SECTION 10. Section 43-62-14.1 of the North Dakota Century Code is created and enacted as follows:

43-62-14.1. Fluoroscopy technologist.

1. Effective August 1, 2019, an individual licensed or permitted as a fluoroscopy technologist by the North Dakota board of medicine who is in good standing on that date, automatically becomes licensed as a fluoroscopy technologist by the North Dakota medical imaging and radiation therapy board.

   a. Effective August 1, 2019, the North Dakota board of medicine shall expire every active fluoroscopy technologist's license issued by that board.

   b. Effective August 1, 2019, the North Dakota medical imaging and radiation therapy board shall issue a fluoroscopy technologist license to every individual qualified under this subsection to be automatically licensed.

2. The scope of practice of a licensed fluoroscopy technologist is limited to gastrointestinal fluoroscopy of the esophagus, stomach, and small and large intestines.

3. Fluoroscopy services provided by a licensed fluoroscopy technologist must be provided under the supervision of a primary supervising physician.

4. If a fluoroscopy technologist performs a fluoroscopy procedure outside the presence of the technologist's primary supervising physician, the technologist must be supervised by an onsite supervising physician who is immediately available to the technologist for consultation and supervision at all times the technologist is performing a fluoroscopy procedure.

5. Under this section, a supervising physician may not designate the fluoroscopy technologist to take over the physician's duties or cover the physician's practice. During an absence or temporary disability of a primary supervising physician, the fluoroscopy technologist is responsible to the substitute primary supervising physician.

6. To qualify for biennial license renewal, a fluoroscopy technologist shall submit to the board with radiography license renewal:

   a. Evidence of completion of at least six hours of continuing education on fluoroscopy safety and relevant radiation protection; and

   b. A copy of an agreement with a primary supervising physician.

7. A licensee under this section is subject to the disciplinary authority of the board under section 43-62-19.

SECTION 11. APPLICATION. To facilitate application of sections 2 and 6 through 10 of this Act, the North Dakota board of medicine shall provide the North Dakota medical imaging and radiation therapy board with the files regarding all active fluoroscopy technologists licensed by the North Dakota board of medicine necessary for the North Dakota medical imaging and radiation therapy board to take over licensure and regulation of these technologists."

Renumber accordingly

Date: 4/15/2019
Roll Call Vote #: 1

2019 SENATE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2094 as (re) engrossed

Senate "Enter committee name" Committee

Action Taken
- ☐ **SENATE accede to House Amendments**
- ☐ **SENATE accede to House Amendments and further amend**
- ☒ **HOUSE recede from House amendments**
- ☐ **HOUSE recede from House amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Representative Porter Seconded by: Senator O. Larsen

Senators				Yes	No		Representatives				Yes	No
Sen. J. Lee				X			Rep. Rohr				X	
Sen. O. Larsen				X			Rep. Porter				X	
Sen. Hogan				X			Rep. Dobervich				X	
Total Senate Vote				3	0		Total Rep. Vote				3	0

Vote Count Yes: 6 No: 0 Absent: 0

Senate Carrier Senator J. Lee House Carrier Representative Rohr

LC Number 19.8055 . 02005 of amendment

LC Number . 05000 of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Takes the majority of the regulations governing the fluoroscopy techs out of the Board of Medicine administrative rules and puts them into statue.

Insert LC: 19.8055.02005
Senate Carrier: J. Lee
House Carrier: Rohr

REPORT OF CONFERENCE COMMITTEE

SB 2094, as engrossed: Your conference committee (Sens. J. Lee, O. Larsen, Hogan and Reps. Rohr, Porter, Dobervich) recommends that the **HOUSE RECEDE** from the House amendments as printed on SJ pages 1263-1269, adopt amendments as follows, and place SB 2094 on the Seventh order:

That the House recede from its amendments as printed on pages 1263-1269 of the Senate Journal and pages 1466-1472 of the House Journal and that Engrossed Senate Bill No. 2094 be amended as follows:

Page 1, line 1, replace the second "and" with a comma

Page 1, line 1, after "43-17-45" insert ", and 43-62-14.1"

Page 1, line 2, after "telemedicine" insert "and the regulation of fluoroscopy technologists"

Page 1, line 2, remove the first "and"

Page 1, line 3, after "43-17-01" insert ", 43-17-02,"

Page 1, line 3, after "43-17-02.3" insert ", subsection 1 of section 43-17.1-02, and sections 43-17.1-05, 43-17.1-05.1, and 43-17.1-06"

Page 1, line 4, replace the second "and" with a comma

Page 1, line 4, after the second "medicine" insert ", and the regulation of fluoroscopy technologists; to provide a penalty; and to provide for application"

Page 2, after line 8, insert:

"**SECTION 2. AMENDMENT.** Section 43-17-02 of the North Dakota Century Code is amended and reenacted as follows:

43-17-02. Persons exempt from the provisions of chapter.

The provisions of this chapter do not apply to the following:

1. Students of medicine or osteopathy who are continuing their training and performing the duties of a resident in any hospital or institution maintained and operated by the state, an agency of the federal government, or in any residency program accredited by the accreditation council on graduate medical education, provided that the North Dakota board of medicine may adopt rules relating to the licensure, fees, qualifications, activities, scope of practice, and discipline of such persons.

2. The domestic administration of family remedies.

3. Dentists practicing their profession when properly licensed.

4. Optometrists practicing their profession when properly licensed.

5. The practice of christian science or other religious tenets or religious rules or ceremonies as a form of religious worship, devotion, or healing, if the person administering, making use of, assisting in, or prescribing, such religious worship, devotion, or healing does not prescribe or administer drugs or medicines and does not perform surgical or physical operations, and if the person does not hold out to be a physician or surgeon.

6. Commissioned medical officers of the armed forces of the United States, the United States public health service, and medical officers of the veterans administration of the United States, in the discharge of their official duties, and licensed physicians from other states or territories if called in consultation with a person licensed to practice medicine in this state.

7. Doctors of chiropractic duly licensed to practice in this state pursuant to the statutes regulating such profession.

8. Podiatrists practicing their profession when properly licensed.

9. Any person rendering services as a physician assistant, if such service is rendered under the supervision, control, and responsibility of a licensed physician. However, sections 43-17-02.1 and 43-17-02.2 do apply to physician assistants. The North Dakota board of medicine shall prescribe rules governing the conduct, licensure, fees, qualifications, discipline, activities, and supervision of physician assistants. Physician assistants may not be authorized to perform any services which must be performed by persons licensed pursuant to chapters 43-12.1, 43-13, 43-15, and 43-28 or services otherwise regulated by licensing laws, notwithstanding the fact that medical doctors need not be licensed specifically to perform the services contemplated under such chapters or licensing laws.

10. A nurse practicing the nurse's profession when properly licensed by the North Dakota board of nursing.

11. ~~A person rendering fluoroscopy services as a radiologic technologist if the service is rendered under the supervision, control, and responsibility of a licensed physician and provided that the North Dakota board of medicine prescribes rules governing the conduct, permits, fees, qualifications, activities, discipline, and supervision of radiologic technologists who provide those services.~~

~~12.~~ A naturopath duly licensed to practice in this state pursuant to the statutes regulating such profession.

~~13.~~12. An individual duly licensed to practice medical imaging or radiation therapy in this state under chapter 43-62.

~~14.~~13. An acupuncturist duly licensed to practice in this state pursuant to the statutes regulating such profession."

Page 2, line 23, after "consultation" insert "on a diagnosis for a patient to a physician licensed in the state,"

Page 3, line 10, replace "valid" with "bona fide"

Page 4, after line 23, insert:

"**SECTION 6. AMENDMENT.** Subsection 1 of section 43-17.1-02 of the North Dakota Century Code is amended and reenacted as follows:

1. For the purpose of investigating complaints or other information that might give rise to a disciplinary proceeding against a physician~~, a~~ or physician assistant~~, or a fluoroscopy technologist~~, the president of the board ~~must~~shall designate two investigative panels, each ~~comprised~~composed of six members of the board. Five members of each

panel must be physician members of the board. One member of each panel must be a public member of the board.

SECTION 7. AMENDMENT. Section 43-17.1-05 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-05. Complaints.

1. Any person may make or refer written complaints to the investigative panels with reference to the acts, activities, or qualifications of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ licensed to practice in this state, or to request that an investigative panel review the qualifications of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ to continue to practice in this state. Any person ~~who~~that, in good faith, makes a report to the investigative panels under this section is not subject to civil liability for making the report. For purposes of any civil proceeding, the good faith of any person ~~who~~that makes a report pursuant to this section is presumed. Upon receipt of any complaint or request, the investigative panel shall conduct the investigation as ~~it~~the panel deems necessary to determine whether any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ has committed any of the grounds for disciplinary action provided for by law. Upon completion of ~~its~~the investigation of the investigative panel, the investigative panel shall make a finding that the investigation discloses that:

   a. There is insufficient evidence to warrant further action;

   b. The conduct of the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ does not warrant further proceedings but the investigative panel determines ~~that~~ possible errant conduct occurred that could lead to significant consequences if not corrected. In such a case, a confidential letter of concern may be sent to the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~; or

   c. The conduct of the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ indicates ~~that~~ the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ may have committed any of the grounds for disciplinary action provided for by law and which warrants further proceedings.

2. If the investigative panel determines ~~that~~ a formal hearing should be held to determine whether any licensed physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ has committed any of the grounds for disciplinary action provided for by law, ~~it~~the panel shall inform the respondent physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ involved of the specific charges to be considered by serving upon that ~~person~~individual a copy of a formal complaint filed with the board for disposition pursuant to the provisions of chapter 28-32. The board members who have served on the investigative panel may not participate in any proceeding before the board relating to ~~said~~the complaint. The complaint must be prosecuted before the board by the attorney general or one of the attorney general's assistants.

3. If an investigative panel finds ~~that~~ there are insufficient facts to warrant further investigation or action, the complaint must be dismissed and the matter is closed. The investigative panel shall provide written notice to the ~~individual or entity~~person filing the original complaint and the ~~person~~individual who is the subject of the complaint of the investigative panel's final action or recommendations, if any, concerning the complaint.

SECTION 8. AMENDMENT. Section 43-17.1-05.1 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-05.1. Reporting requirements - Penalty.

1. A physician, a physician assistant~~, or a fluoroscopy technologist~~, a health care institution in the state, a state agency, or a law enforcement agency in the state having actual knowledge that a licensed physician~~, a~~ or physician assistant~~, or a fluoroscopy technologist~~ may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board promptly shall ~~promptly~~ report that information in writing to the investigative panel of the board. A medical licensee or any institution from which the medical licensee voluntarily resigns or voluntarily limits the licensee's staff privileges shall report that licensee's action to the investigative panel of the board if that action occurs while the licensee is under formal or informal investigation by the institution or a committee of the institution for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment.

2. Upon receiving a report concerning a licensee an investigative panel shall, or on its own motion an investigative panel may, investigate any evidence that appears to show a licensee is or may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board.

3. A person required to report under this section ~~who~~that makes a report in good faith is not subject to criminal prosecution or civil liability for making the report. For purposes of any civil proceeding, the good faith of any person ~~who~~that makes a report pursuant to this section is presumed. A physician who obtains information in the course of a physician-patient relationship in which the patient is another physician is not required to report if the treating physician successfully counsels the other physician to limit or withdraw from practice to the extent required by the impairment. A physician who obtains information in the course of a professional peer review pursuant to chapter 23-34 is not required to report pursuant to this section. A physician who does not report information obtained in a professional peer review is not subject to criminal prosecution or civil liability for not making a report. For purposes of this section, a person has actual knowledge if that person acquired the information by personal observation or under circumstances that cause that person to believe there exists a substantial likelihood that the information is correct.

4. An agency or health care institution that violates this section is guilty of a class B misdemeanor. A physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ who violates this section is subject to administrative action by the board as specified by law or by administrative rule.

SECTION 9. AMENDMENT. Section 43-17.1-06 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-06. Powers of the board's investigative panels.

The board's investigative panels may:

1. Subpoena witnesses and physician and hospital records relating to the practice of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ under investigation. The confidentiality of the records by any other statute or law does not affect the validity of an investigative panel's

subpoena nor the admissibility of the records in board proceedings; however, the proceedings and records of a committee ~~that~~which are exempt from subpoena, discovery, or introduction into evidence under chapter 23-34 are not subject to this subsection.

2. Hold preliminary hearings.

3. Upon probable cause, require any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ under investigation to submit to a physical, psychiatric, or competency examination or chemical dependency evaluation.

4. Appoint special masters to conduct preliminary hearings.

5. Employ independent investigators ~~when~~if necessary.

6. Hold confidential conferences with any complainant or any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ with respect to any complaint.

7. File a formal complaint against any licensed physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ with the board.

SECTION 10. Section 43-62-14.1 of the North Dakota Century Code is created and enacted as follows:

43-62-14.1. Fluoroscopy technologist.

1. Effective August 1, 2019, an individual licensed or permitted as a fluoroscopy technologist by the North Dakota board of medicine who is in good standing on that date, automatically becomes licensed as a fluoroscopy technologist by the North Dakota medical imaging and radiation therapy board.

   a. Effective August 1, 2019, the North Dakota board of medicine shall expire every active fluoroscopy technologist's license issued by that board.

   b. Effective August 1, 2019, the North Dakota medical imaging and radiation therapy board shall issue a fluoroscopy technologist license to every individual qualified under this subsection to be automatically licensed.

2. The scope of practice of a licensed fluoroscopy technologist is limited to gastrointestinal fluoroscopy of the esophagus, stomach, and small and large intestines.

3. Fluoroscopy services provided by a licensed fluoroscopy technologist must be provided under the supervision of a primary supervising physician.

4. If a fluoroscopy technologist performs a fluoroscopy procedure outside the presence of the technologist's primary supervising physician, the technologist must be supervised by an onsite supervising physician who is immediately available to the technologist for consultation and supervision at all times the technologist is performing a fluoroscopy procedure.

5. Under this section, a supervising physician may not designate the fluoroscopy technologist to take over the physician's duties or cover the physician's practice. During an absence or temporary disability of a primary supervising physician, the fluoroscopy technologist is responsible to the substitute primary supervising physician.

6. To qualify for biennial license renewal, a fluoroscopy technologist shall submit to the board with radiography license renewal:

   a. Evidence of completion of at least six hours of continuing education on fluoroscopy safety and relevant radiation protection; and

   b. A copy of an agreement with a primary supervising physician.

7. A licensee under this section is subject to the disciplinary authority of the board under section 43-62-19.

SECTION 11. APPLICATION. To facilitate application of sections 2 and 6 through 10 of this Act, the North Dakota board of medicine shall provide the North Dakota medical imaging and radiation therapy board with the files regarding all active fluoroscopy technologists licensed by the North Dakota board of medicine necessary for the North Dakota medical imaging and radiation therapy board to take over licensure and regulation of these technologists."

Renumber accordingly

Engrossed SB 2094 was placed on the Seventh order of business on the calendar.

2019 TESTIMONY

SB 2094

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SB 2094

Madam Chair, Senator Lee
Vice Chair, Senator Larsen
Senator Anderson
Senator Clemens
Senator Hogan
Senator Roers

Good morning members of the Human Services Committee

My name is Bonnie Storbakken. I am the Executive Secretary for the North Dakota Board of Medicine.

I am here on behalf of the Board of Medicine to introduce SB 2094 to you. This Bill attempts to provide parameters for our licensees regarding the practice of telemedicine and provide the structure necessary to fulfill the mission of the Board to protect the public through the regulation of the Practice of Medicine.

First, I would like to provide some historical context. Second, I will walk through each section of the Bill. And third I will talk about some examples our Board has seen causing the Board to begin the process of putting these parameters in place. Fourth, I will address the other places in law this body has addressed telemedicine. Fifth, I will discuss model policy proposed by the American Medical Association, (AMA) and Federation of State Medical Boards, (FSMB) and tell you what other states are currently doing. And lastly, I will discuss some of the opposition.

Historical Context: The Bill you see before you was proposed as a rule through the Administrative Rules process. I have attached the pertinent portion of the minutes from the Administrative Rules Hearings as well as the final Rule that was put into place. Along with each packet submitted to the Administrative Rules Committee.

(Attachment 1, Current Rule; The packets submitted to the Administrative Rules Committee in December 2017 and March 2018 with the pertinent portion of the minutes attached to each packet have been provided separately as Historical documents)

The result of the Administrative Rules process left much of the language out of our rule and directed the Board to address this matter with the legislature rather than through the rule making process. It is no secret that the language proposed by the Board was met with opposition in the rule making process and I would anticipate within the legislative process as well. I can assure you that it is not the intent of the Board to be overly burdensome or restrictive. Rather it is the intent to prevent harm and provide parameters to guide practice.

SB 2094:

SECTION 1

Section one of the bill provides definitions for "Licensee" and for "Telemedicine".

SECTION 2

Section two of the bill provides that practice is deemed to occur where the patient is and that a licensee providing care to a patient located in ND must be licensed in ND.

SECTION 3

Section three of the Bill is the source of much of the opposition that was seen within the rules process. This section is intended to ensure that all practice done through telemedicine is held to the same standard of care as traditional or in person medical care. Number/ subsection one in this section speaks to the scope of practice and states that licensees provide care within their scope of education, training and expertise.

Number/ subsection two of this section states that a patient-licensee relationship must be established prior to the diagnosis and treatment of a patient. This subsection also states the licensee must verify the identity of the patient and disclose their identity to the patient.

Number/subsection three is intended to provide clarity in how to establish a patient-licensee relationship if one does not already exist. If the relationship is being established through the use of telemedicine this section makes clear the initial examination must be done with the use of video and or an appropriately licensed intervening health care provider. It was important for the Board to be clear that the use of audio conversation or an online static questionnaire would not be an acceptable means to establish the patient-licensee relationship. Once a relationship is established the use of telemedicine to provide care would be at the discretion of the licensee. This subsection also attempts to carve out exceptions to the patient-licensee relationship requirement for certain types of telemedicine such as teleradiology and ICU monitoring.

Number/subsection four is intended to provide clarity that medical records must be maintained under our current laws regardless of the delivery of the care. Number/ subsection five is intended to ensure that proper referrals will be made if the patient is not amenable to diagnosis through telemedicine.

SECTION 4

Section four of the bill is intended to ensure that any and all prescribing done through telemedicine must adhere to all state and Federal Laws including the rules regarding the Prescription Drug Monitoring Program, (PDMP) reporting requirements. This section also provides parameters for opioid prescribing. The opioid prescribing section was amended in the Administrative rules process to allow an exception to the ban on opioid prescribing for MAT purposes. The reasoning for prohibiting the prescription of opioids was in response to the opioid prescribing issues seen across the nation.

Examples of Concern:

A patient complaint that the "physician" they were consulting with would not disclose their identity.

Patients that received cold calls asking questions about their medication and then received unsolicited prescription medications in the mail.

Complaint that unnecessary testing was being done through a telemedicine practice for purposes of improper billing.

These are just a few examples that are concerning to the Board of Medicine. If a relationship exists between a licensee and a patient these incidents are decreased, and tools are provided in a clear way for the Board to address the issue.

Other ND Laws that Mention Telemedicine:

NDCC 26.1-36-09.15 Coverage of telehealth services: this statute defines telehealth and provides the parameters for payment of telehealth services. It should be noted that this statute also states that telehealth does not include audio only telephone, electronic mail, or facsimile transmissions.

(Attachment 2: NDCC 26.1-36-09.15)

N.D.C.C. 19-24.1-01(3) provides a definition of provider-patient relationship:

"Bona fide provider-patient relationship" means a treatment or counseling relationship between a health care provider and patient in which all the following are present: The summary of the requirements listed are a review of the patient's medical records and current medical condition including an in person medical evaluation of the patient and a requirement to maintain records.

(Attachment 3 NDCC 19-24.1-01(3))

AMA and FSMB Model Policy:

I have attached model language drafted by the AMA regarding telemedicine. You can see from the language that our Bill is in line with what the AMA has proposed as good policy for telemedicine. Both our Bill and the AMA proposed language require licensure in the state where the patient is located. Both require that prior to treating a patient via telemedicine there must first be a physician-patient relationship. The AMA language includes verifying the identity of the patient and physician. The AMA language sets out requirements for consents, diagnosing, follow up care and medical records.

(Attachment 4 AMA Model language)

The FSMB model policy is less prescriptive in its approach to providing policy guidance but it also touches on the same areas and requirements of establishing a relationship, ensuring the ability to confirm the identity of both the patient and physician, referrals, medical records.

The overall approach set out by the model language as well as the Boards bill aim to affirm that the standard of care is maintained regardless of the delivery method of the medical care. I have attached the FSMB Model Language as well as a letter addressed to this committee from the President of the FSMB in support of this Bill.

(Attachment 5 FSMB Model Language)

Criticism of the Rule:

The requirement of video is overly burdensome due to a lack of broadband availability to many rural patients. I have attached a ND broadband report which states that North Dakota has some of the best broadband coverage in the nation. I have also attached a recent article published in the Grand Forks Herald which discusses North Dakota's Broadband in relation to the National picture. Also, let's consider that it was not that long ago that all patients had to travel to a physician to be treated every time they required treatment. A onetime video and or in person visit to establish care is still an advancement from an in person visit every time one needs care.

(Attachment 6 Broadband Article and Report)

The comments received during the Administrative Rules process can be found within attachment 1 and 2. I would like to point out that our Board has taken public comments during two open comment periods which included scheduled hearings for public. Additionally, our Board reviewed and discussed comments made after the comment period during the Administrative Rules hearing process. Our Board feels strongly even after listening to and discussing all comments that the Patient- Licensee relationship language is necessary to provide the parameters needed to its licensees and to provide the framework from which to review complaints received relating to telemedicine.

At the Boards November 2018 meeting I was directed to submit an agency bill for telemedicine using the language that was used in the rule making process. Once the language was complete it was sent out in a blast email to all our licensees. I have attached the feedback I received from that blast email.

(Attachment 7 recent emails from licensees)

Bonnie Storbakken
Executive Secretary, NDBOM
701-328-6500
bstorbakken@ndbom.org

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ATTACHMENT 1

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NORTH DAKOTA
Board of Medicine

Telemedicine Rule Effective 1-1-18

CHAPTER 50-02-15

TELEMEDICINE

50-02-15-01. Definitions. As used in this chapter:

1. "Telemedicine" means the practice of medicine using electronic communication, information technologies, or other means between a licensee in one location and a patient in another location, with or without an intervening health care provider. The term includes direct interactive patient encounters as well as asynchronous store-and-forward technologies and remote monitoring.

2. "Licensee" means a physician or physician assistant licensed to practice in North Dakota. A physician assistant practicing telemedicine from another state is subject to the rules regarding physician supervision, except that supervision may be by a North Dakota licensed physician who is practicing telemedicine in North Dakota and need not be by a North Dakota licensed physician who is physically located in North Dakota.

50-02-15-02. Prescribing.

A licensee who has performed a telemedicine examination or evaluation meeting the requirements of this chapter may prescribe medications according to the licensee's professional discretion and judgment. Opioids may only be prescribed through telemedicine if done so as a federal Food and Drug Administration approved medication assisted treatment for opioid use disorder. Opioids may not be prescribed through a telemedicine encounter for any other purpose.

Licensees who prescribe controlled substances, as defined by North Dakota law, in circumstances allowed under this rule, shall comply with all state and federal laws regarding the prescribing of controlled substances, and shall participate in the North Dakota prescription drug monitoring program.

more news

ATTACHMENT 2

26.1-36-09.11. Breast reconstruction surgery.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, or franchise basis unless the policy, contract, or evidence of insurance provides the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998 [Pub. L. 105-277; 112 Stat. 2681-337; 42 U.S.C. 300gg-6]. This section does not apply to individual or group supplemental, specified disease, long-term care, or other limited benefit policies.

26.1-36-09.12. Medical services related to suicide.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any hospital, surgical, medical, or major medical benefit policy on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any individual covered under the policy or contract for injury or illness resulting from suicide, attempted suicide, or self-inflicted injury. The medical benefits provided for in this section are exempt from section 54-03-28.

26.1-36-09.13. Medical services related to intoxication.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any major medical expense policy on a group, individual, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any individual covered under the policy or contract for injury or illness resulting from any loss sustained or contracted in the consequence of the insured's being intoxicated or under the influence of any narcotic. The coverage required under this section may be subject to limitations under subdivision g of subsection 2 of section 26.1-36-04 or subsection 15 of section 26.1-36-05.

26.1-36-09.14. Coverage of cancer treatment medications.

1. As used in this section:
   a. "Cancer treatment medications" means prescription drugs and biologics that are used to kill, slow, or prevent the growth of cancerous cells.
   b. "Insurer" means an insurance company, nonprofit health service corporation, or health maintenance organization.
   c. "Patient-administered" includes oral administration and self-injection.
   d. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.
2. An insurer may not deliver, issue, execute, or renew a policy that provides coverage for cancer treatment medications that are injected or are intravenously administered by a health care provider and that provides coverage for patient-administered cancer treatment medications unless the policy copayment, deductible, and coinsurance amounts for patient-administered cancer treatment medications do not exceed the amounts for cancer treatment medications that are injected or are intravenously administered by a health care provider, regardless of the formulation or benefit category.
3. An insurer may not increase a copayment, deductible, or coinsurance amount for covered cancer treatment medications that are injected or intravenously administered in order to avoid compliance with subsection 2. An insurer may not reclassify benefits with respect to cancer treatment medications in a manner that is inconsistent with this section.

26.1-36-09.15. Coverage of telehealth services.

1. As used in this section:

a. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.
b. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.
c. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.
d. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.
e. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.
f. "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.
g. "Telehealth":
   (1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.
   (2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.
   (3) Does not include the use of audio-only telephone, electronic mail, or facsimile transmissions.

2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.
3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner as the insurer with the health services providers in the same manner as the insurer establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.
4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.
5. This section does not require:
   a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;
   b. A policy to provide coverage for health services delivered by means of telehealth if the policy would not provide coverage for the health services if delivered by in-person means;
   c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or
   d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

ATTACHMENT 3

40. "Written certification" means a form established by the department which is executed, dated, and signed by a health care provider within ninety calendar days of the date of application, stating that in the health care provider's professional opinion the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition. A health care provider may authorize the use of dried leaves or flowers of the plant of the genus cannabis in a combustible delivery form to treat or alleviate the patient's debilitating medical condition. A written certification may not be made except in the course of a bona fide provider-patient relationship.

19-24.1-02. Medical marijuana program.

The department shall establish and implement a medical marijuana program under this chapter to allow for production and processing, the sale and dispensing of usable marijuana, and medical use of marijuana. A person may not produce or process or sell, possess, transport, dispense, or use marijuana or usable marijuana under the medical marijuana program unless the person is authorized to do so as a compassion center, a cardholder, or otherwise authorized by rule adopted under this chapter.

19-24.1-03. Qualifying patients - Registration.

1. A qualifying patient is not eligible to purchase, use, or possess usable marijuana under the medical marijuana program unless the qualifying patient has a valid registry identification card.
2. A qualifying patient application for a registry identification card is complete and eligible for review if an applicant submits to the department:
   a. A nonrefundable annual application fee in the amount of fifty dollars, with a personal check or cashier's check payable to "North Dakota State Department of Health, Medical Marijuana Program".
   b. An original written certification, which must include:
      (1) The name, address, and telephone number of the practice location of the applicant's health care provider;
      (2) The health care provider's North Dakota license number;
      (3) The health care provider's medical or nursing specialty;
      (4) The applicant's name and date of birth;
      (5) The applicant's debilitating medical condition and the medical justification for the health care provider's certification of the patient's debilitating medical condition;
      (6) Attestation the written certification is made in the course of a bona fide provider-patient relationship and that in the provider's professional opinion the applicant is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the applicant's debilitating medical condition;
      (7) Whether the health care provider authorizes the patient to use the dried leaves or flowers of the plant of the genus cannabis in a combustible delivery form; and
      (8) The health care provider's signature and the date.
   c. An original qualifying patient application for a registry identification card form established by the department which must include all of the following:
      (1) The applicant's name, address, and date of birth.
      (2) The applicant's social security number.
      (3) The name, address, and date of birth of the applicant's proposed designated caregiver, if any.
      (4) A photographic copy of the applicant's North Dakota identification. The North Dakota identification must be available for inspection and verification upon request of the department. If the applicant is a minor, a certificated copy of a birth record is required.

(5) The applicant's or guardian's signature and the date, or in the case of a minor, the signature of the minor's parent or legal guardian with responsibility for health care decisions and the date.

d. A signed consent for release of medical information related to the applicant's debilitating medical condition, on a form provided by the department.

e. A recent two-by-two inch [5.08-by-5.08 centimeter] photograph of the applicant.

f. Any other information or material required by rule adopted under this chapter.

3. If the applicant is unable to submit the required application information due to age or medical condition, the individual responsible for making medical decisions for the applicant may submit the application on behalf of the applicant. The individual responsible for making medical decisions:

a. Must be identified on the qualifying patient application for a registry identification card; and

b. Shall provide a copy of the individual's North Dakota identification. The North Dakota identification must be available for inspection and verification upon the request of the department.

4. If the applicant is a minor, the department may waive the application or renewal fee if:

a. The parent or legal guardian of the applicant is the applicant's registered designated caregiver; and

b. The applicant resides with the applicant's registered designated caregiver.

19-24.1-04. Designated caregivers - Registration.

1. A designated caregiver is not eligible to purchase, assist in the use of, or possess usable marijuana under the medical marijuana program unless the designated caregiver has a valid registry identification card.

2. A designated caregiver application is complete and eligible for review if an applicant submits to the department all of the following:

a. A nonrefundable annual application fee in the amount of fifty dollars, with a personal check or cashier's check made payable to "North Dakota State Department of Health, Medical Marijuana Program".

b. An original designated caregiver application for a registry identification card form established by the department which must include all of the following:

(1) A certified copy of a birth record verifying the applicant is at least twenty-one years of age.

(2) A photographic copy of the applicant's North Dakota identification. The North Dakota identification must be available for inspection and verification upon request of the department.

(3) The name, address, telephone number, and date of birth of the qualifying patient.

(4) The name, address, and telephone number for the qualifying patient's health care provider.

(5) The name, address, and telephone number of the applicant.

(6) The applicant's social security number.

(7) The applicant's signature and the date.

c. An original designated caregiver authorization form established by the department which must be executed by a registered qualifying patient providing the designated caregiver applicant with the responsibility of managing the well-being of the registered qualifying patient with respect to the registered qualifying patient's medical use of marijuana. The form must include:

(1) The name and date of birth of the designated caregiver applicant; and

(2) The registered qualifying patient's signature and the date.

d. A recent two-by-two inch [5.08-by-5.08 centimeter] photograph of the applicant.

e. Any other information or material required by the department by rule.

3. A criminal history record check conducted under section 12-60-24 must be performed upon initial application and biennially thereafter and at any other time upon the request

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AMA AMERICAN MEDICAL ASSOCIATION

IN THE GENERAL ASSEMBLY STATE OF _____

Telemedicine Act

Be it enacted by the People of the State of _____, represented in the General Assembly:

Section 1. Title. This act shall be known as and may be cited as the Telemedicine Act.

Section 2. Definitions.

(A) "Telemedicine" or "telehealth" means health care services provided to a patient who is at a remote location.

(B) "Store and forward" transfer means the transmission of a patient's medical information from an originating site to the physician at the distant site without the patient being present.

(C) "Distant site" means a site at which a physician is located while providing health care services by means of telemedicine.

(D) "Originating site" means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine.

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Section 3. Licensure.

(A) Physicians treating patients in [State] through telemedicine or telehealth must be fully licensed to practice medicine in [State] and shall be subject to regulation by the [State] Board of Medicine.

(B) This section does not apply to:

(1) An informal consultation or second opinion, at the request of a physician licensed to practice medicine in this state, provided that the physician requesting the opinion retains authority and responsibility for the patient's care; and

(2) Furnishing of medical assistance by a physician in case of an emergency or disaster if no charge is made for the medical assistance.

***Drafting Note**—to provide further guidance on exceptions to telemedicine licensure, this drafting note provides a representative sample from states with telemedicine licensure laws.*

(3) Consultation services provided by a physician located in another jurisdiction to a medical school as defined in [Statute] or an institution defined in [Statute governing other schools of health (e.g. dental school, school of public health, school of nursing)]; and

(4) Ordering home health or hospice services for a resident of this state to be delivered by a home and community support services agency licensed by this state, by the resident's treating physician who is located in another jurisdiction of a state having borders contiguous with the borders of this state.

(C) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting or in a manner not otherwise authorized by the laws of this state.

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Section 4. Evaluation and Treatment of the Patient.

(A) Telemedicine shall not be utilized by a physician with respect to any patient located in [State] in the absence of a physician-patient relationship.

(B) Physicians who utilize telemedicine shall, if such action would otherwise be required in the provision of the same service not delivered via telemedicine, ensure that a proper physician-patient relationship is established which at a minimum includes:

(1) (a) an appropriate face-to-face examination prior to diagnosis and treatment of the patient, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or

(b) a consultation with another physician who has an ongoing relationship with the patient, provided that the physician requesting the consultation retains authority and responsibility for the patient's care;

(2) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient;

(3) disclosing and validating the physician's identity and applicable credential(s);

(4) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including informed consents regarding the use of telemedicine technologies as indicated in Section 5;

(5) establishing a diagnosis through the use of acceptable medical practices, including patient history, mental status examination, physical examination (unless not warranted by the patient's mental condition), and appropriate diagnostic and laboratory testing to establish diagnoses, as well as identify underlying conditions or contra-indications, or both, to treatment recommended or provided;

(6) discussing with the patient the diagnosis and the evidence for it, the risks and benefits of various treatment options;

(7) ensuring the availability of appropriate follow-up care; and

(8) providing a visit summary to the patient.

(C) The requirements of Section 4(B) do not apply to:

(a) emergency situations in which there is an occurrence that poses an imminent threat of a life-threatening condition or severe bodily harm.

(b) treatment provided in an on-call or cross-coverage situation. An "on-call" physician is a [State] licensed physician who is available to physically attend, if necessary, to urgent and follow up care needs of a patient for whom he or she has temporarily assumed responsibility as designated by the patient's treating physician. A "covering" physician means a physician who conducts a medical evaluation other than an in-person medical evaluation at the request of a physician who has conducted at least one (1) in-person medical evaluation of the patient within the previous twelve (12) months and who is temporarily unavailable to conduct the evaluation of the patient.

(D) Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of care as those in traditional (encounter in person) settings.

***Drafting Note re: Medical Home**—States may wish to include language recommending that, if a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.*

Drafting Note re: Online Prescribing—*To provide further guidance on provisions addressing prescribing in response to online or telephone questionnaires, states may wish to include the following language:*

(E) Without a prior and proper physician-patient relationship, physicians are prohibited from issuing prescriptions solely in response to an Internet questionnaire, email message, or audio-only telephone consult.

Drafting Note re: Exceptions—*States may wish to address the application of this section to specialty practice such as radiology, neurology, pathology, dermatology and others, as appropriate, where the application of technology in medical practice is well established, defined and constitutes the standard of care.*

Section 5. Coverage of telemedicine services.

(A) Each carrier offering a health plan in this state shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

(B) A carrier offering a health plan in this state shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a physician and a patient for services appropriately provided through telemedicine services.

(C) A carrier offering a health plan in this state shall not be required to reimburse the treating physician or the consulting physician for technical fees or costs for the provision of telemedicine services; however, such carrier shall reimburse the treating physician or the consulting physician for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the carrier is responsible for coverage for the provision of the same service through in-person consultation or contact.

(D) A carrier offering a health plan in this state may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through in-person diagnosis, consultation, or treatment.

(E) No carrier offering a health plan in this state shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(F) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in [State] on and after January 1, 20__, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(G) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

***Drafting Note re: Utilization Review and Prior Authorization**—States may wish to include the following provision regarding utilization review and prior authorization:*

(H) Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services,

provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan, and provided all adverse determinations are made by a physician who possesses a current and valid non-restricted license to practice medicine in [State] and is board certified or eligible in the same specialty as the physician who typically manages the medical condition or disease or provides the health care service. Any such utilization review shall not require prior authorization of emergent telemedicine services.

Section 6. Informed Consent.

(A) The physician must follow applicable state and federal statutes and regulations for informed consent.

Section 7. Privacy Practices.

(A) The physician must follow applicable state and federal statutes and regulations for privacy and security of individually identifiable health information.

Section 8. Medical Records.

(A) The physician treating a patient through telemedicine must maintain a complete record of the patient's care.

(B) The physician must disclose the record to the patient consistent with state and federal laws.

(C) The physician must follow applicable state and federal statutes and regulations for medical recordkeeping and confidentiality.

Section 9. Fraud and Abuse

(A) The physician must follow applicable state and federal statutes and regulations for fraud and abuse.

Section 10. Effective. This Act shall become effective immediately upon being enacted into law.

Section 11. Severability. If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

Adopted November 2014; revised November 2015.

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FEDERATION OF STATE MEDICAL BOARDS

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup

Adopted as policy by the Federation of State Medical Boards in April 2014

INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)[1] and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients[2] via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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[1] *The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).*

[2] *The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.*

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MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider.[3] However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.[4]

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.[5]

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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[3] *See Center for Telehealth and eHealth Law (Ctel), http://ctel.org/ (last visited Dec. 17, 2013).*

[4] *Id.*

[5] *See Cal. Bus. & Prof. Code § 2290.5(d).*

- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.[7]

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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[6] *American Medical Association, Council on Ethical and Judicial Affairs, Fundamental Elements of the Patient-Physician Relationship (1990), available at http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf.*

[7] *See Ctel.*

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

Licensure:
A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.[8]

Establishment of a Physician-Patient Relationship:
Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

Evaluation and Treatment of the Patient:
A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:
Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

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[8] *Federation of State Medical Boards, A Model Act to Regulate the Practice of Medicine Across State Lines (April 1996), available at http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf.*

Continuity of Care:
Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services:
An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Medical Records:
The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records & Exchange of Information:
Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information," issued by the Department of Health and Human Services (HHS).[9] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

[9] *45 C.F.R. § 160, 164 (2000).*

results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:
Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit form that pharmacy.

Prescribing:

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Section Five. Parity of Professional and Ethical Standards

Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician's practice.

A physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.

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FEDERATION OF
STATE MEDICAL BOARDS

January 8, 2019

Senator Judy Lee, Chairwoman
Human Services Committee
North Dakota State Senate
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Chairwoman Lee and Members of the Committee,

On behalf of the Federation of State Medical Boards (FSMB), I would like to take this opportunity to comment on Senate Bill 2094. The FSMB urges the Committee to support this legislation.

The FSMB is a national, non-profit organization whose members include the 70 state medical and osteopathic licensing and disciplinary boards of the United States and its territories, and the District of Columbia, including the North Dakota Board of Medicine. The FSMB serves as a collective voice for state medical boards with the goal of improving and advancing the nation's state medical regulatory system.

The FSMB provides a variety of services to support state medical boards in carrying out their statutory responsibilities to protect the public, including developing model policies and identifying "best practices" for states. As such, the FSMB is well positioned to comment on Senate Bill 2094.

In 2014, the FSMB's House of Delegates unanimously approved the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.* This policy was developed by a workgroup comprised of members and senior staff of state medical boards, representatives from the telemedicine provider community and legal experts. A draft was distributed to FSMB member boards and other stakeholders for comment prior to its adoption. The *Model Policy* is therefore a consensus document providing guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educating licensees as to the appropriate standards of care in the delivery of medical services directly to patients via telemedicine technologies.

Senate Bill 2094 reflects the standards adopted in the *Model Policy*, specifically in the following areas:

- The *Model Policy* defines telemedicine as, "the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of

secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient." Both Section 2 (§43-17-01 (5)) and Section 3 (§43-17-02.3(3)(a)) of SB 2094 meet the guidelines established within the *Model Policy*.

- The *Model Policy* states, "the [physician-patient] relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient." It continues to state that "a physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient." SB 2094, specifically Section 4 (§43-17-44(2)), adheres to FSMB's *Model Policy*.

- The *Model Policy* states, "prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person." Section 5 (§43-17-45) of SB 2094 meets the guidelines adopted within the *Model Policy*.

For the aforementioned reasons, the FSMB believes that Senate Bill 2094 will reduce regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while protecting the public's health and safety.

Again, I thank you for the opportunity to comment on Senate Bill 2094 and urge you to support this legislation.

Sincerely,

Humayun J. Chaudhry, DO, MACP

Humayun J. Chaudhry, DO, MACP
President and Chief Executive Officer

cc: Members of the North Dakota Senate Human Services Committee

ATTACHMENT 6

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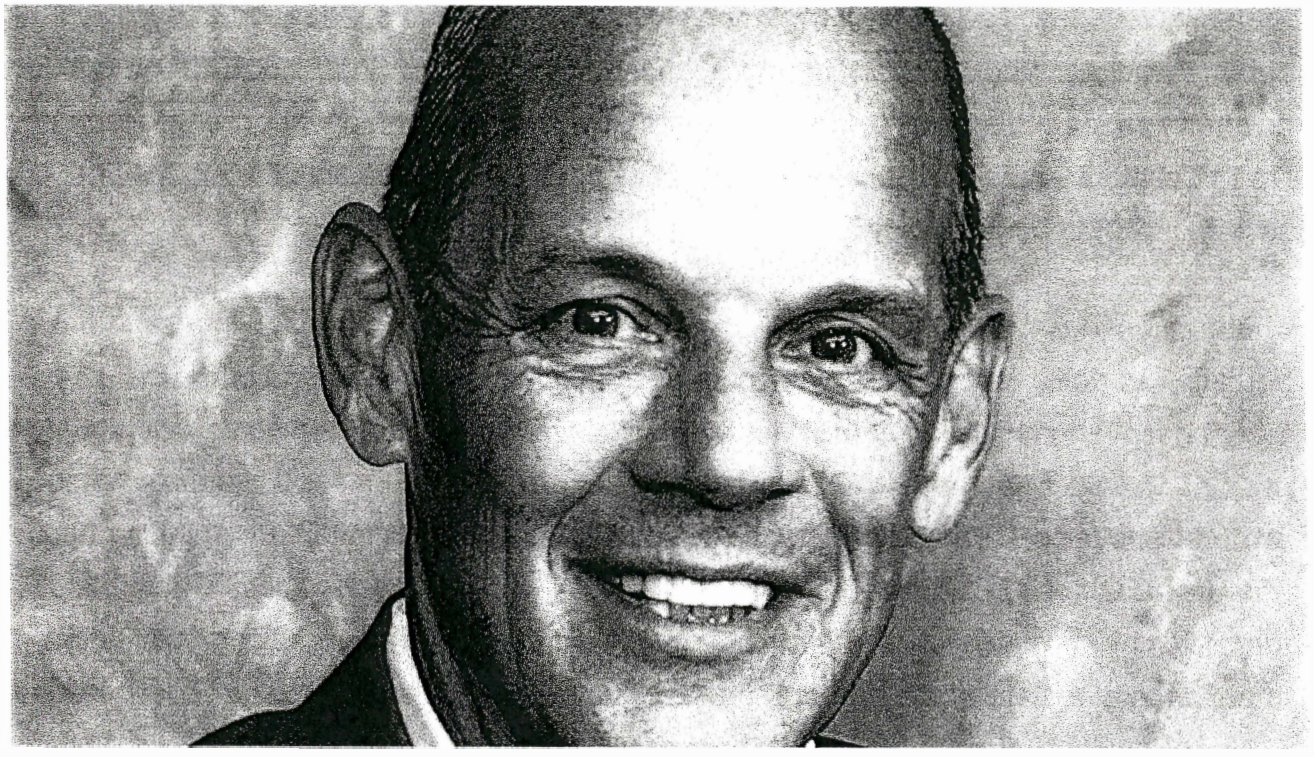
Severe Weather Announcements (3)

Letter: Lack of broadband access? Not in N.D.

By **David Crothers** on Apr 28, 2018 at 8:31 a.m.



By David Crothers

This month, the Forum Communications Co. publication Agweek wrote that "39 percent of Rural Americans lack access to Rural Broadband." That is debatable and subject to interpretation on a nationwide basis but is wildly inaccurate in North Dakota.

North Dakota quite possibly has the most "connected" rural broadband infrastructure and

residents of any state in the country. As you will recall, it was just a month ago (March 21)

Gov. Doug Burgum announced that North Dakota would be the first state in the nation to

connect every school—elementary, middle, high school and institution of higher education—with Gig (gigabit) service.

Gigabit service, it is often said, is about 100 times faster than most homes in the United States have today. The Federal Communications Commission defines "broadband" as being 25 megabits downstream and three megabits upstream. Gigabit is 1,000 megabits downstream, or 40 times faster than the U.S. Government's own definition of broadband. North Dakota's telecom cooperatives and small commercial companies offer gigabit service in 288 communities today.

That tremendous feat is only possible because of the existing broadband infrastructure and a billion-dollar investment by telecommunications cooperatives and other independent and locally- owned telecom providers. Those 18 companies serve 96 percent of North Dakota's geographic territory and employ over 1,000 men and women. That local ownership is critical. The decisions on where to invest and how much are made around boardroom tables in Carrington and Park River and Hazen instead of somewhere else in the nation by someone who has never visited North Dakota, much less appreciates the importance of a state of the art broadband network for rural residents. The dollars earned in North Dakota are reinvested in the broadband infrastructure and the customers they serve. No one understands the critical need for affordable access to high-speed Internet for their educational, economic, medical and entertainment opportunities more than rural residents.

Those North Dakota-based telecom companies providing broadband in the highest-cost, lowest- density areas of the state don't just take that fiber-based infrastructure to schools or the most profitable customers or the edge of town. They are committed to ensuring that all residents of the state have access to it. It is as important for a rancher to be able to buy through online auctions as it is for a home health care nurse to be able to send images to a big city physician from a patient's home or students connect with online educational for

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video instruction. Locally- owned broadband providers recognize that and design a network to make sure they are not forgotten.

David Crothers, of Mandan, is executive vice president of the North Dakota Association of Telecommunications Cooperatives.

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INTERNET SERVICE IN NORTH DAKOTA

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INTERNET ACCESS IN NORTH DAKOTA

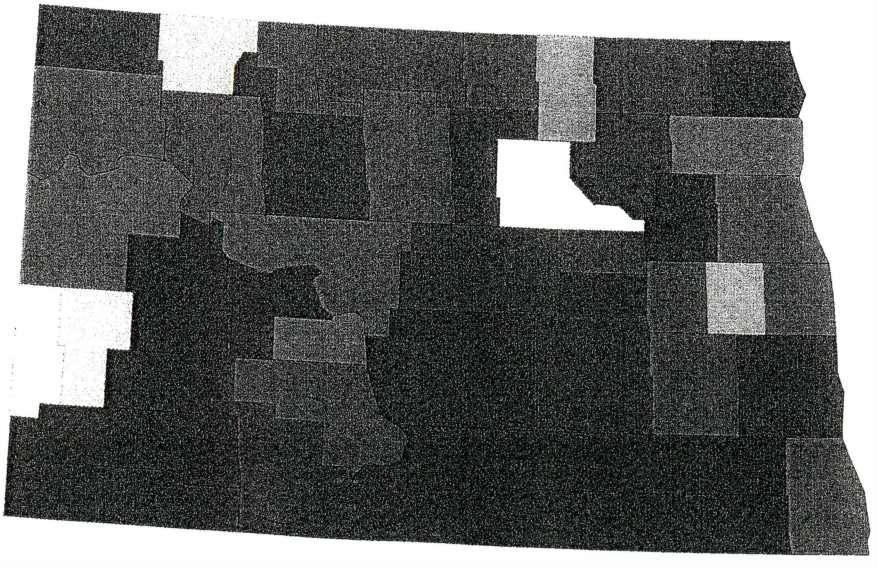
Speed Guide

ARE YOU A JOURNALIST OR RESEARCHER WRITING ABOUT THIS TOPIC?

Send us a question and we'll connect you with a broadband market expert who can answer your question and provide a unique pullquote.

Submit Question

COVERAGE BY COUNTY



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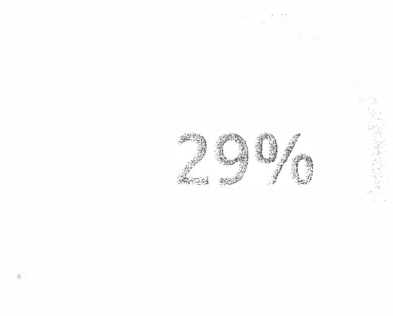
25+ mbps | 100+ mbps | 1 Gbit

BROADBAND COVERAGE



POPULATION UNDERSERVED

31.7

MBPS AVERAGE
STATE-WIDE SPEED

17th

MOST
CONNECTED STATE

BROADBAND SPEEDS

93.5% of North Dakotans have access to wired broadband 25mbps or faster.

91.6% of North Dakotans have access to broadband 100mbps or faster.

72.3% of North Dakotans have access to 1 gigabit broadband.

WIRED COVERAGE

97.0% of North Dakotans have access to wireline service.

41.8% of North Dakotans have access to fiber-optic service.

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89.0% of North Dakotans have access to service.

70.7% of North Dakotans have access to service.

WIRELESS COVERAGE

100.0% of North Dakotans have access to service.

48.0% of North Dakotans have access to service.

LARGEST COMPETING PROVIDERS IN NORTH DAKOTA

1.

TOP 5 FASTEST CITIES IN NORTH DAKOTA

	City	Avg. Download Speed	No. of Providers
1.		93.8 MBPS	8 Providers
2.		86.8 MBPS	7 Providers
3.		77.2 MBPS	7 Providers
4.	Golden Valley	70.3 MBPS	7 Providers
5.		64.1 MBPS	8 Providers

SPEEDS FOR MAJOR PROVIDERS IN NORTH DAKOTA

Provider	Avg. Download Speed
	38.3 MBPS
	25.7 MBPS
	22.2 MBPS
	13.8 MBPS
	7.1 MBPS

GOV'T FUNDING

Since 2010, has been awarded $3,664,087 in federal grants for .

Another $10,781,157, accounting for 0.3% of all federal infrastructure grants, was awarded to broadband infrastructure projects in North Dakota.

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Since 2011, access to a wired connection of at least 10mbps has improved from 78.8% to 95.2% of North Dakotans.

QUICK STATS

In total there are 92 internet providers in North Dakota.

There are 45,000 people in North Dakota without access to a wired connection capable of 25mbps download speeds.

There are 178,000 people in North Dakota that have access to only one wired provider, leaving them no options to switch.

Another 21,000 people in North Dakota don't have any wired internet providers available where they live.

Sources: Data collected via the FCC, NTIA, and other sources. For a full list of data sources please visit our data page.

NORTH DAKOTA CITIES

City	Broadband Coverage	Average speed over time	# of Providers
Bismarck	99.4%		12 providers
Devils Lake	99.3%		8 providers
Dickinson	100.0%		10 providers
Fargo	99.6%		16 providers
Grafton	80.0%		9 providers
Grand Forks	91.8%		13 providers
Jamestown	99.0%		9 providers
Mandan	91.7%		9 providers
Minot	96.5%		8 providers

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City	Broadband Coverage	Average speed over time	# of Providers
[illegible]	98.6%		7 providers
[illegible]	100.0%		8 providers
[illegible]	99.1%		11 providers
[illegible]	82.6%		10 providers
[illegible]	99.2%		14 providers
[illegible]	94.9%		8 providers

COPY LINK TO CLIPBOARD

https://broadbandnow.com/North-Dakota

Home › North Dakota

Last Updated on 11/13/2018.

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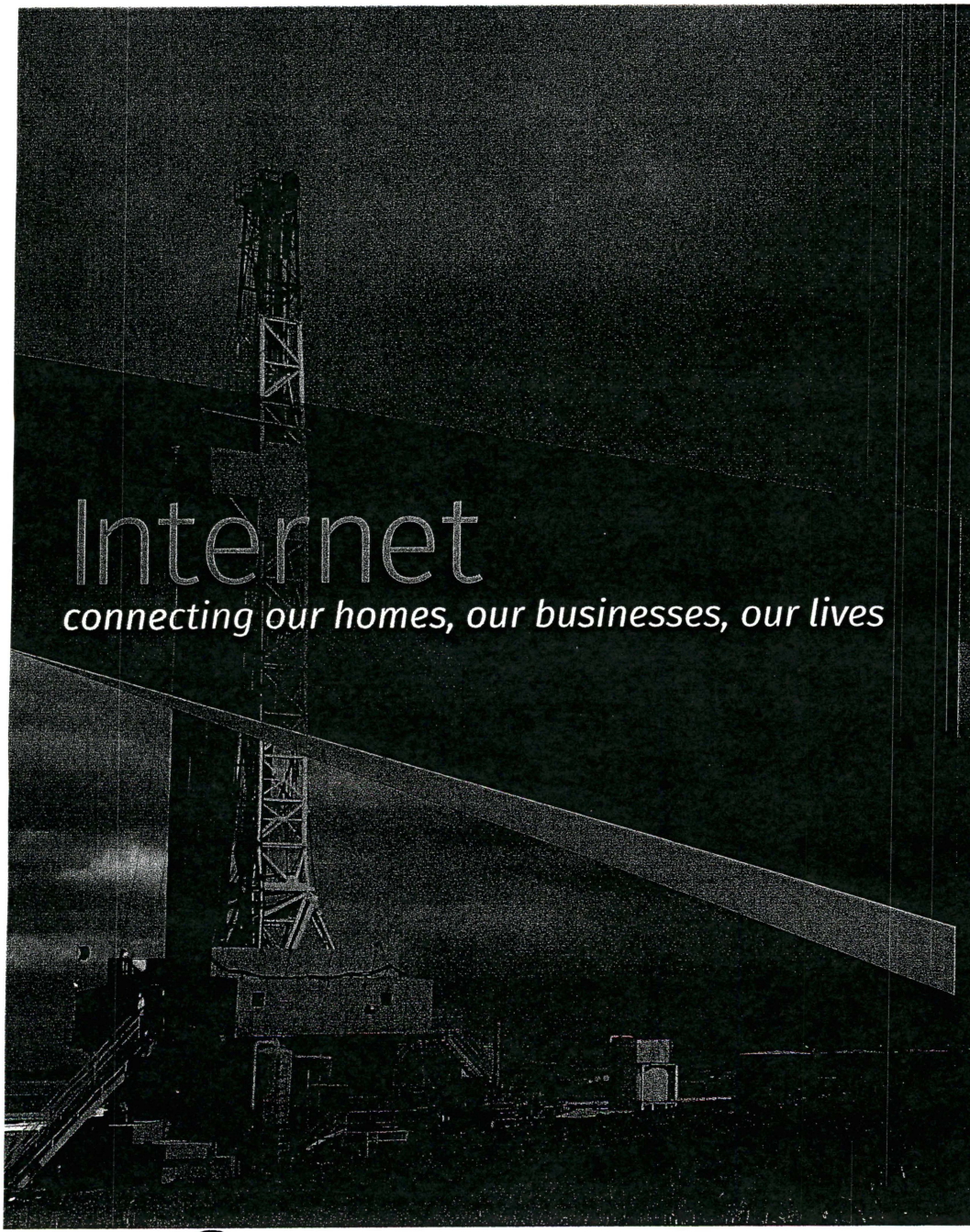
North Dakota Broadband Report

Connecting the World to North Dakota

2015



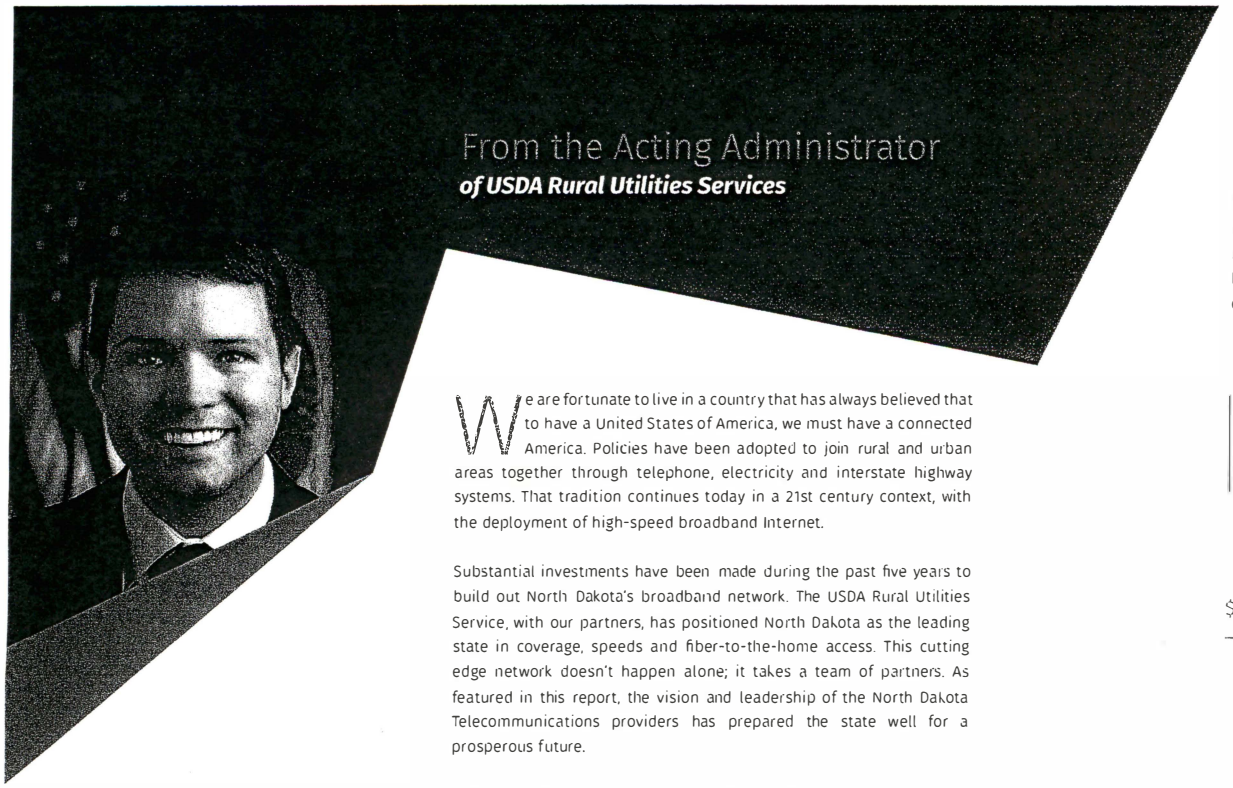
Internet

connecting our homes, our businesses, our lives

At its best, human connection is what the Internet is all about. ***It's the video that goes viral*** that you can't wait to share with your friends. It's sending ***photos of your kids*** to your parents, who won't believe how they've grown. It's ***catching up with old friends*** on Facebook. It's sending that email at work that ***helps your business grow.*** It's ***streaming that movie online*** on a Saturday night with your kids and your spouse. It's the attachment that ***makes the whole office cheer.*** It's the ***article*** you send to a friend who has just been diagnosed. It's the ***video chat*** with your son overseas in the military. The Internet is woven into the fabric of our days, and ***we can't imagine life without it.***

This North Dakota Broadband Report shares the ***good news:*** the availability of high-speed broadband Internet and fiber-to-the-home technology is ***booming*** in North Dakota. The report also tells the stories of ***people like you***—businesswomen and men, students, working from their homes, people trying to make their lives work, people looking for a ***human connection***—and how North Dakota's Internet infrastructure has ***changed their lives for the better.*** In every case, ***the story is the same:*** individuals and businesses throughout North Dakota are thriving because of the connection broadband offers.

Your Internet connection isn't something you should have to worry about, or even think about. It should be there for you, like a ***reliable friend.*** This report shows that, without a doubt, ***you have a friend in North Dakota's broadband networks.***



From the Acting Administrator
of USDA Rural Utilities Services

"To have a United States of America, we must have a connected America.

"Access to a high-speed connection will fundamentally change the way we live, work, and do business.

We are fortunate to live in a country that has always believed that to have a United States of America, we must have a connected America. Policies have been adopted to join rural and urban areas together through telephone, electricity and interstate highway systems. That tradition continues today in a 21st century context, with the deployment of high-speed broadband Internet.

Substantial investments have been made during the past five years to build out North Dakota's broadband network. The USDA Rural Utilities Service, with our partners, has positioned North Dakota as the leading state in coverage, speeds and fiber-to-the-home access. This cutting edge network doesn't happen alone; it takes a team of partners. As featured in this report, the vision and leadership of the North Dakota Telecommunications providers has prepared the state well for a prosperous future.

Access to a high-speed connection will fundamentally change the way we live, work, and do business. It opens up opportunities to telework or start a business. Our farmers and ranchers have access to real-time market information. Distance learning offers students access to more classes and the chance to obtain a degree from home. The high-speed connection also opens the door to telemedicine opportunities that never existed before. Of course, there are also the social benefits—staying connected to their friends and loved ones.

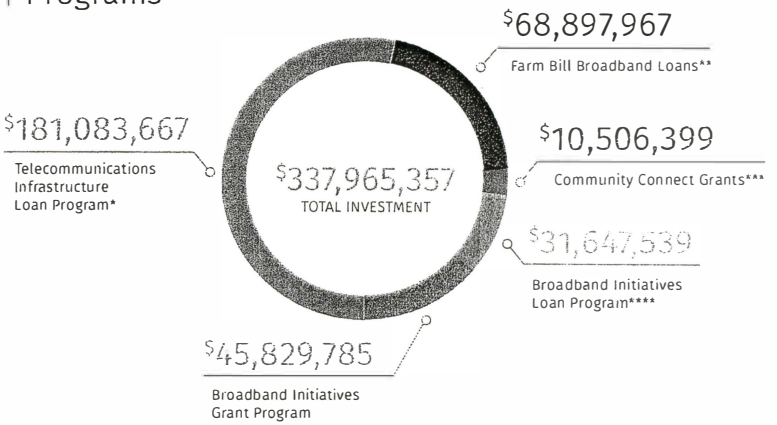
Please enjoy this North Dakota Broadband Report, which highlights the substantial work already done and the work left to do. Once again, North Dakota is leading the way.

Jasper Schneider
Acting Administrator
USDA Rural Utilities Service

Broadband Investments in North Dakota

Broadband is the infrastructure of the 21st century. Since 2009, USDA has invested more than $330 million in North Dakota telecommunications and broadband projects, of that total investment, more than $56 million was granted and $281 million was loaned to local North Dakota Internet service providers to help build out and provide better service to their customers. These investments provide economic development, educational, health care, social and public safety benefits to improve the quality of life for North Dakotans.

USDA Telecommunication Programs



* The Telecommunications Infrastructure Loan Program makes long-term direct and guaranteed loans to qualified organizations for the purpose of financing the improvement, expansion, construction, acquisition, and operation of telephone lines, facilities, or systems to furnish and improve telecommunications service in rural areas.

** The Farm Bill Broadband Program is designed to provide loans for funding, on a technology-neutral basis, for the costs of construction, improvement, and acquisition of facilities and equipment to provide broadband service to eligible rural communities.

*** The Community Connect program serves rural communities where broadband service is least likely to be available, but can make a tremendous difference in the quality of life for citizens. The projects funded by these grants will help rural residents tap into the enormous potential of the Internet.

**** The Broadband Initiatives Program (BIP) was established in response to the American Recovery and Reinvestment Act of 2009 (Recovery Act). The primary goal of the Recovery Act was to provide a fiscal boost to the nation during the economic crisis. Providing access to broadband services will increase economic development and improve the quality of life for all Americans. BIP funding for loans, grants, and loan/grant combinations will help address the challenge of rapidly expanding the access and quality of broadband services across rural America and meeting the objectives of the Recovery Act.

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From the Chief Executive Officer
of Dakota Carrier Network

Dakota Carrier Network's fiber optic network promotes business opportunities. Dakota Carrier Network (DCN) and its 15 independent rural telephone companies are committed to serving the citizens of North Dakota—it's the reason we have collectively invested more than $100 million per year in fiber infrastructure for the last decade. This $1.3 billion investment to put 40,000 miles of fiber optics in the ground extends ultra-high-speed broadband capabilities to every corner of the state. DCN's high-speed network enables businesses to compete on a worldwide stage as data travels across North Dakota or around the world.

The State of North Dakota recognizes this investment in technology and deploys DCN's network to bring gigabit-capable broadband services to 300+ locations across the state including state agencies, higher education institutions, and K-12 school districts.

DCN's fiber optic network is supported 24 hours a day, seven days a week by industry-certified, highly skilled technicians in a state-of-the-art Network Operations Center in Bismarck. DCN's carrier-grade-hardened facility is engineered to meet and exceed high availability standards. This is crucial since DCN provides network connectivity to North Dakota's most critical institutions, including health care, public safety, state government, schools, and financial organizations among others relying on broadband service to perform their daily business activities.

DCN and its member companies will continue to invest, upgrade and provide world-class broadband service to North Dakota consumers.

Seth Arndorfer
Chief Executive Officer
Dakota Carrier Network (DCN)

"DCN's high-speed network enables businesses to compete on a worldwide stage as data travels across North Dakota or around the world.

"DCN provides network connectivity to North Dakota's most critical institutions.

From the Executive Vice President
of the North Dakota Association of Telecommunications Cooperatives

The 18 independent telecommunications companies in North Dakota have long demonstrated a commitment to meeting the evolving needs of their members and customers. In the past, the telecom cooperatives and small commercial companies satisfied all of their consumers' needs by providing quality, affordable phone service. Those days have long passed—today's rural customer requires an array of sophisticated offerings to access the entertainment, educational and economic opportunities others in the world enjoy.

The challenge is huge—cooperative and small commercial members serve 96 percent of the state's geographic territory—and the investment is substantial. Yet there are no alternatives to this investment: in the past, telecom companies offered a menu of services from which customers could pick and choose. Today, that same consumer determines the services they want and how much they are willing to spend for speed, capacity and content.

North Dakota independent telecom companies have responded aggressively, in many cases with the assistance of USDA Rural Development offices. Each company in the state is committed to building out fiber-to-the-home in the shortest time possible. Several telcos have a 100% fiber network and more will be added each year until—we predict—every rural North Dakotan will have access to gigabit speed by 2019.

Today, our customers hold online livestock auctions, watch movies, participate in classes at top universities and send vast amounts of research data across our networks. We don't know how they will use our network in the future, but we are committed to building the infrastructure that allows them to meet their needs.

David Crothers
Executive Vice President/General Manager
North Dakota Association of Telecommunications Cooperatives (NDATC)

"Today's rural customer requires an array of sophisticated offerings to access the entertainment, educational and economic opportunities others in the world enjoy.

"Every rural North Dakotan will have access to gigabit speed by 2019.

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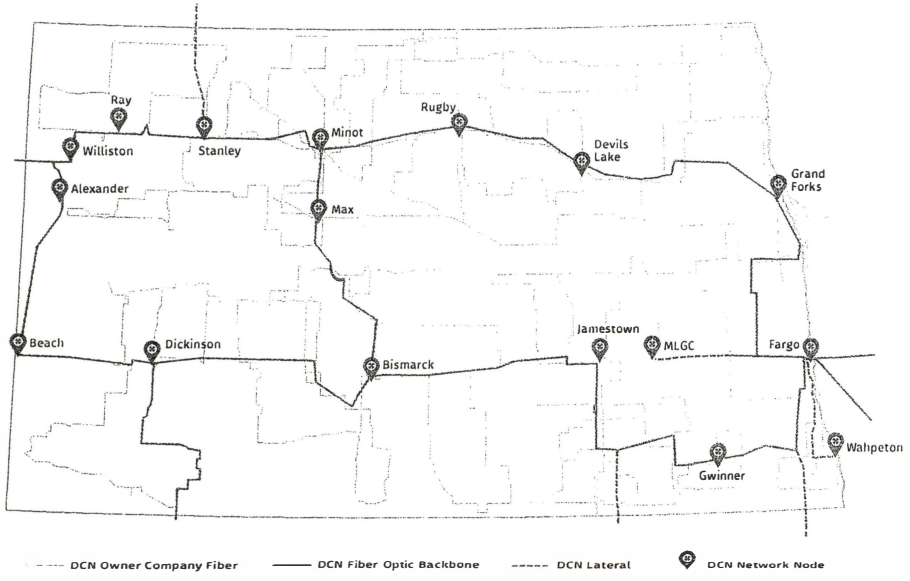
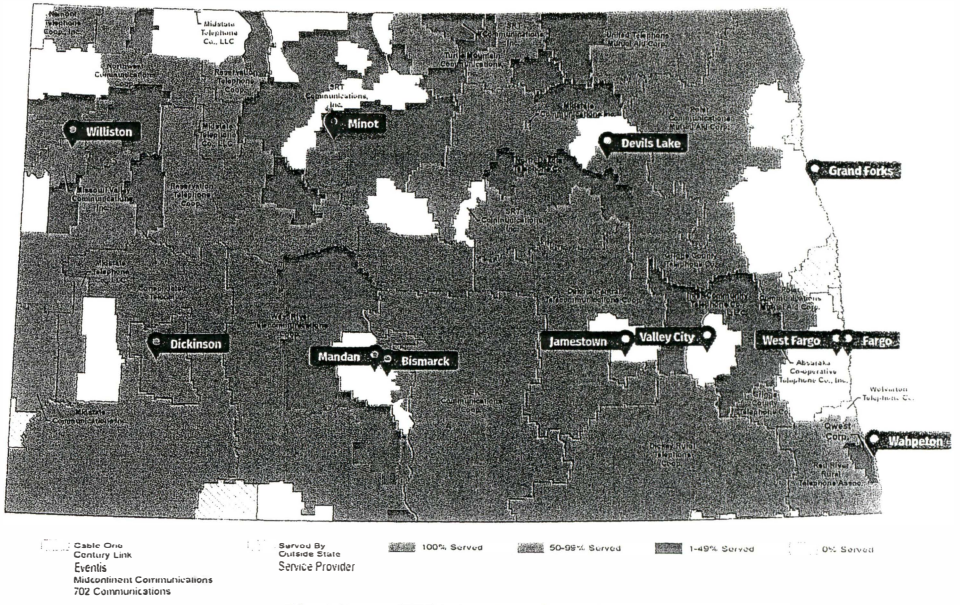
Broadband
Capacity Maps

On average in the United States, only 5% of households have fiber Internet, but the maps below illustrate the remarkable coverage of fiber in North Dakota. As the coverage map shows, local telcos provide fiber to most of our state's rural areas, in many areas offering 100% coverage. In other words, in these communities 100% of homes and businesses are fiber-ready. The fiber backbone map reveals the immense network created by these telcos, which branches off the Dakota Carrier Network.

North Dakota- Backbone Fiber



North Dakota- Exchanges Served by Fiber



*Fiber To The Home (FTTH) deployed by end of year 2015. Map data based on area served.

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How Broadband
Connects Our Lives

Connecting to nature:
where the song birds sing and the data streams

Perched atop 16,000 acres of rolling hills and lush wetlands, the visitors center at the Arrowwood National Wildlife Refuge hosts thousands of schoolchildren, hikers, bird watchers and nature enthusiasts every year. Wetland district manager Stacy Whipp has the best of both worlds: a rewarding career in the great outdoors and a fiber connection to help her track species, report data and preserve natural resources. "Having a broadband connection has been fantastic," Stacy says, "It's enabled us to get data from a wide variety of places. Before we had to ship CDs, and now they can drop it right onto our server." The connection Arrowwood enjoys allows them to link sister stations within the Refuge grounds while connecting beyond its boundaries.

Connecting through education:
head of the class

The mission of the K-12 Ellendale Public School is to develop adaptive citizens for an ever-changing world by providing challenging opportunities to reach or exceed expectations.

Technology is fully integrated into the learning process, with all levels using tablet computers and programs such as Learn 360, Brain Pop and Ellendale Webcasts. Jeff Fastnacht, Superintendent, says, "We are very proud of our technology integration in our school... Our daily life is filled with the Internet and technology just as much as California or New York, and we have better access." Even though the median household income of the student population is only $35,500, these children are using advanced technologies to further their education.

Connecting to new industry:
North Dakota's black gold

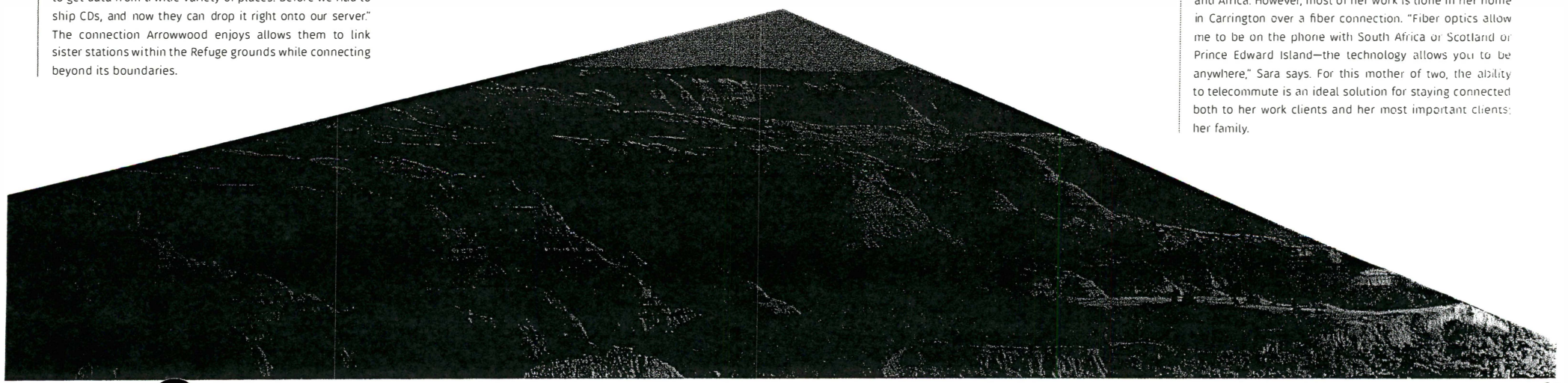
Enduro Operating, LLC is an oil and gas exploration and acquisition/exploitation company near the town of Newburg, population 100. Their previous T1 connections were costing the company thousands of dollars per month and providing minimal speeds. To conduct their day-to-day operations more efficiently and maintain constant communication with their headquarters in Fort Worth, they upgraded to fiber. "Our entire operation is dramatically faster," said Rob Braun, Director of Information Technology. "We recently ran speed tests and are showing speeds of up to 300 Mbps – something we'd never seen prior to fiber, nor would we have ever been able to get." Braun attributes running successful off site backups to fiber.

Connecting to grow:
harvesting the fruits of fiber

Wade Hohertz's company in Mott switched from copper cable to fiber optics in June 2010. Previously, with a satellite Internet connection, the company experienced service disruptions on rainy or cloudy days due to weather-related outages. As a crop insurance adjuster, Wade's work depends on a reliable Internet connection. "We have not had one outage since fiber was installed. All my work is on the Internet uploading and downloading claims. Sending files was so frustrating, because I would try for hours and hours to send my files. My company offers many online training classes, but before fiber it would take forever to participate. Having fiber has changed my life, and I love it!"

Connecting from the home:
international businesswoman and local mom

North Dakota is the main sunflower-growing region for Technology Crops International, a supply chain management firm for the global distribution of seed oil. As General Manager of the North American Division, Sara Anderson's job occasionally takes her to South America, Europe, Asia and Africa. However, most of her work is done in her home in Carrington over a fiber connection. "Fiber optics allow me to be on the phone with South Africa or Scotland or Prince Edward Island—the technology allows you to be anywhere," Sara says. For this mother of two, the ability to telecommute is an ideal solution for staying connected both to her work clients and her most important clients: her family.



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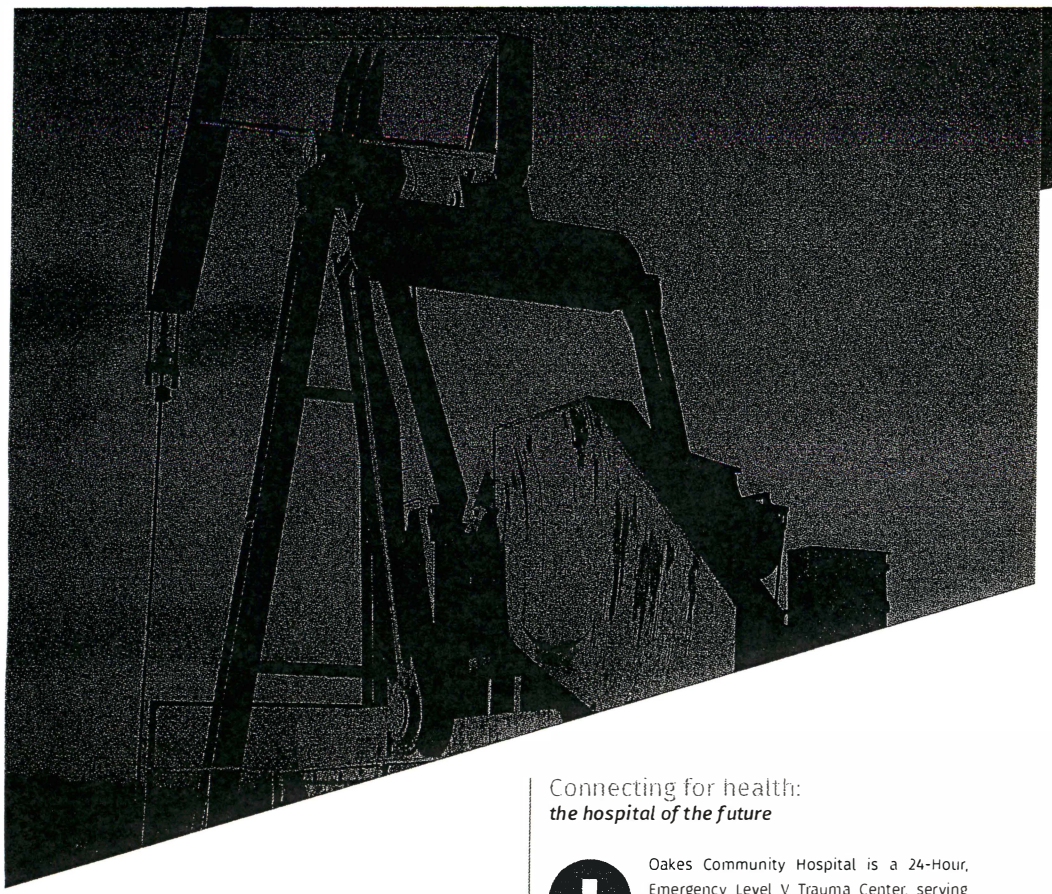


Connecting systems:
Internet through the pipes

BakkenLink Pipeline LLC has worked with their provider to establish fiber connections along their pipeline systems. This connection works through the Dakota Carrier Network, which connects BakkenLink to the world. Darren Snow, Vice President of BakkenLink, says, "These circuits tie into our supervisory control and data acquisition system, which provides oversight of our pipeline. The circuits enable us to run the most current versions of pipeline leak detection software, which allows us to see real-time data on the pipeline and run transient models to look for leaks in real time."

Connecting for health:
the hospital of the future

Oakes Community Hospital is a 24-Hour, Emergency Level V Trauma Center, serving approximately 14,000 people in southeastern North Dakota. The medical staff consists of providers who are multi-specialists in family practice, internal medicine, cardiology, sports medicine and geriatrics. The hospital uses fiber optic broadband and other advanced technologies to diagnose conditions and provision services. Oakes Community Hospital was the first North Dakota hospital to roll out and utilize e-emergency—which allows doctors to video conference with other doctors and specialists directly in the treatment room—and other technologies like e-Consultation and PADNet.

Connecting small to large:
big business in a town of 427

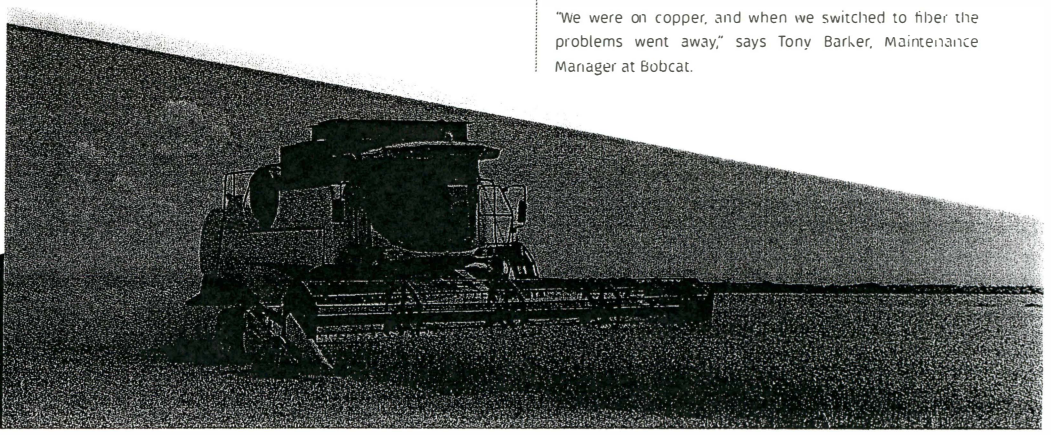
Basin Service Company Inc., located south of Westhope (population 427), is an oil field service company providing a variety of services to the oil industry. The company, founded as Ward Williston in the 1950s, has remained a constant in the small community through the years. Basic switched from copper to fiber, allowing them to have faster Internet speeds than ever, clearer phone calls, and a new way of doing business. Jean Brandt, Human Resources Administrator, says, "In the past, it could take days to do bookkeeping. Some of our employees could only do certain functions at the same time or we'd have too many people on the system and it wouldn't work." She noted that though this company chose to locate their office near a small town, they can still conduct business like companies in major cities.

Connecting for livelihood:
three businesses from one home office

Laura Shipley lives in Kidder County, where she and her family run three businesses from their home: a farm/ranch operation, an electrical contracting business called Shipley Electric, and a small photography business called Snap Shots Photography. Given harsh winters and road closings, being able to work from home is, as Laura puts it, "an awesome benefit – we rely on our high speed Internet for our livelihood. It puts us on a level playing field with cities that have the advantage of advanced technology. We have access to everything they do and we're able to keep up with them and be competitive!"

Connecting to build:
Bobcat spotted in North Dakota

A giant animal has been spotted in Gwinner! But don't worry, it won't bite. This animal is Bobcat Company, North Dakota's largest manufacturer, with the most extensive compact equipment distribution network in the world. The low cost of living, abundant community resources and access to a dedicated labor force of more than 1,500 employees are ideal conditions for Bobcat's production facility in Gwinner to thrive. Their fiber connection links them to other company locations around the world. "We were on copper, and when we switched to fiber the problems went away," says Tony Barker, Maintenance Manager at Bobcat.



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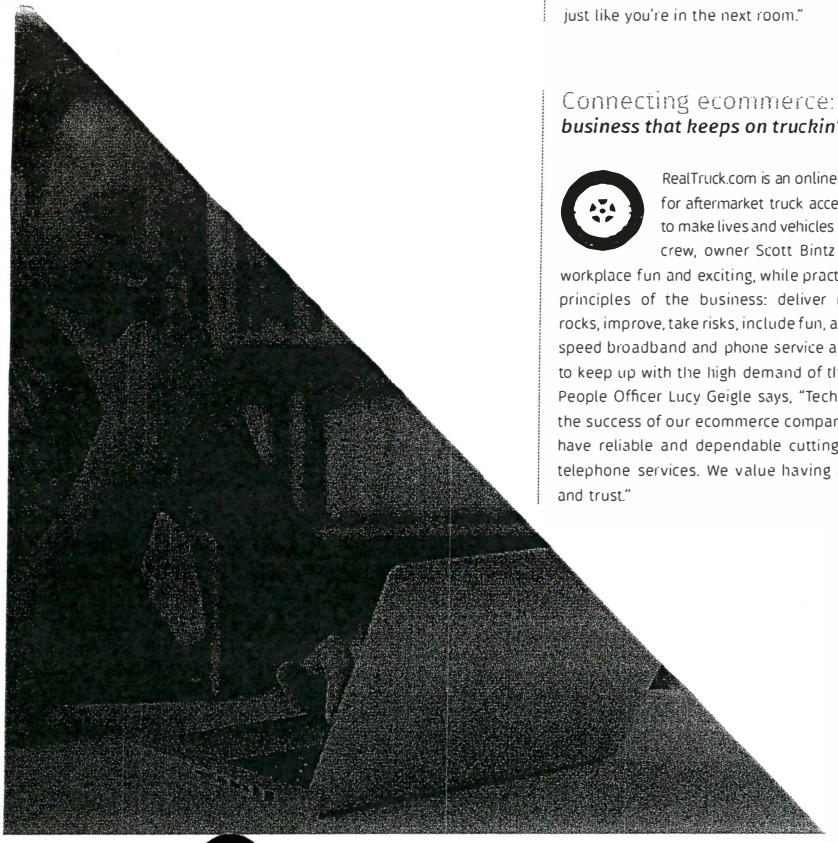
Connecting for our lives:
mixing office and home to make things work

Mary Jo Wicks, a nurse practitioner at the women's clinic of St Joseph's hospital, was thrilled to get fiber installed in her Richardton home. Before the fiber installation, Mary Jo would stay late at the clinic to finish paperwork because she had no reliable Internet at her home to complete the day's paperwork. Leaving the clinic around 8 p.m. each evening, Mary Jo would miss dinner with her husband and kids. With fiber-to-the-home, she enjoys a family meal, spends the evening with her husband and children and then takes care of paperwork after the kids are asleep. "Fiber has improved our quality of life 100%!"

Connecting to family:
from Brazil, with love

Ultimately, the Internet is about connecting not only our businesses, but our lives as well. When Soraia Henson moved to Carrington, North Dakota from Brazil, she left behind a large circle of family and friends, not to mention the tropical weather. Adjusting to the winters, though, has been easy compared to life without her social network. But today, Soraia sees her friends and family daily using a webcam over a fiber connection. She even organizes video chat rooms, filled with familiar faces, all gabbing together in Portuguese! "It's the best thing that's ever happened in our life," Soraia says, "because it's easy and you can see just like you're in the next room."



Connecting ecommerce:
business that keeps on truckin'

RealTruck.com is an online retailer in Jamestown, for aftermarket truck accessories, on a mission to make lives and vehicles better. Along with his crew, owner Scott Bintz strives to keep the workplace fun and exciting, while practicing the six guiding principles of the business: deliver more, transparency rocks, improve, take risks, include fun, and be humble. High-speed broadband and phone service allows RealTruck.com to keep up with the high demand of the industry. As Chief People Officer Lucy Geigle says, "Technology is critical to the success of our ecommerce company. It is important to have reliable and dependable cutting-edge Internet and telephone services. We value having a partner we know and trust."

Thank You
to Our Sponsors

Thank you to the sponsors of the North Dakota Broadband Report—USDA, NDATC, DCN and the telecommunications companies that make North Dakota a leader in Internet connectivity.

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WRT, Hazen	www.westriv.com

USDA United States Department of Agriculture

NDATC

DCN Dakota Carrier NETWORK

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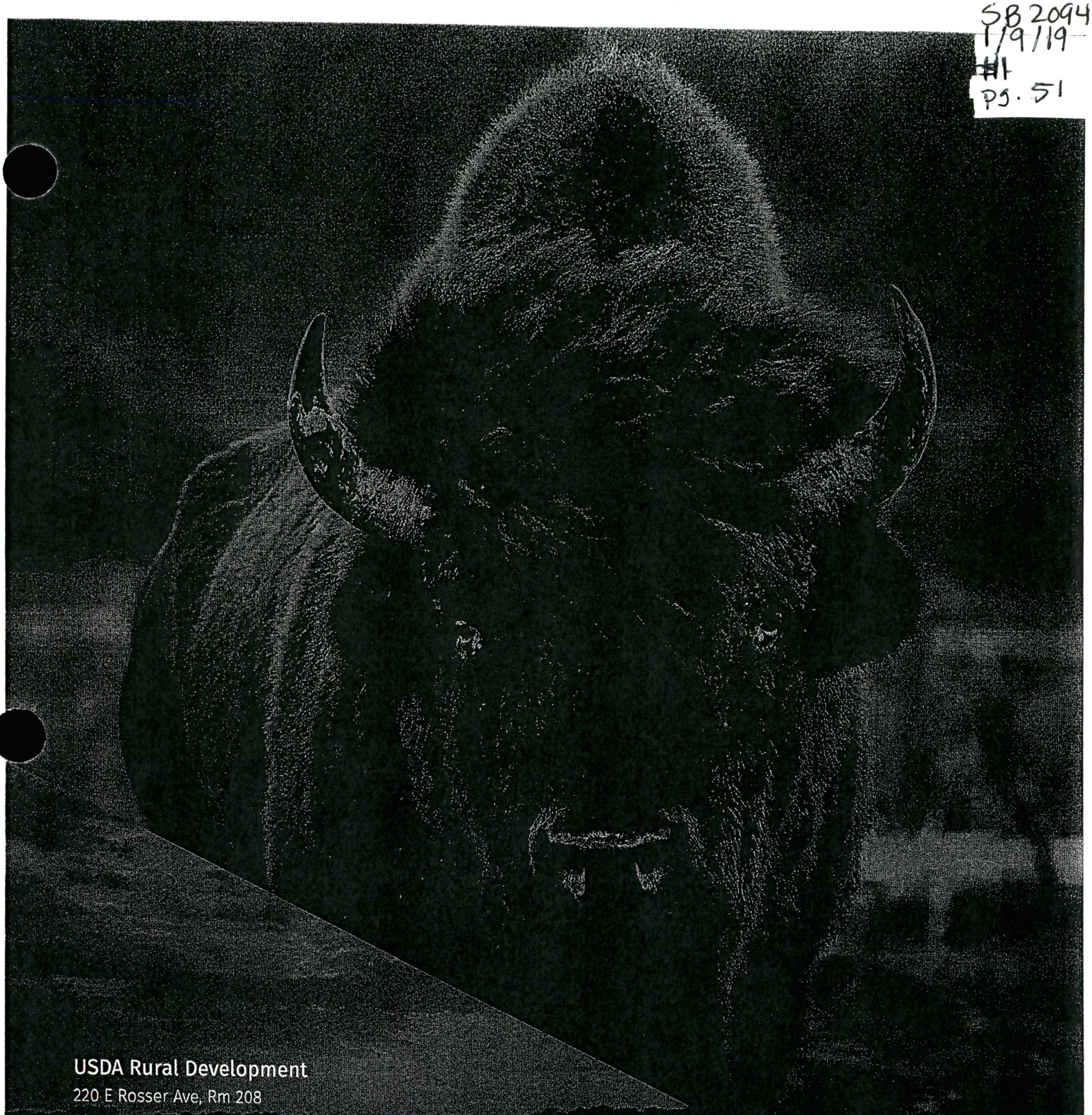

USDA Rural Development
220 E Rosser Ave, Rm 208
Bismarck, ND 58502-1737
701.530.2037
info@nd.usda.gov
www.rurdev.usda.gov/ND

North Dakota Association of Telecommunications Cooperatives
3201 Nygren Dr. NW, PO Box 1144
Mandan, ND 58554
701.663.1099
www.ndatc.com

Dakota Carrier Network
4202 Coleman St.
Bismarck, ND 58503
701.258.2124
www.dakotacarrier.com

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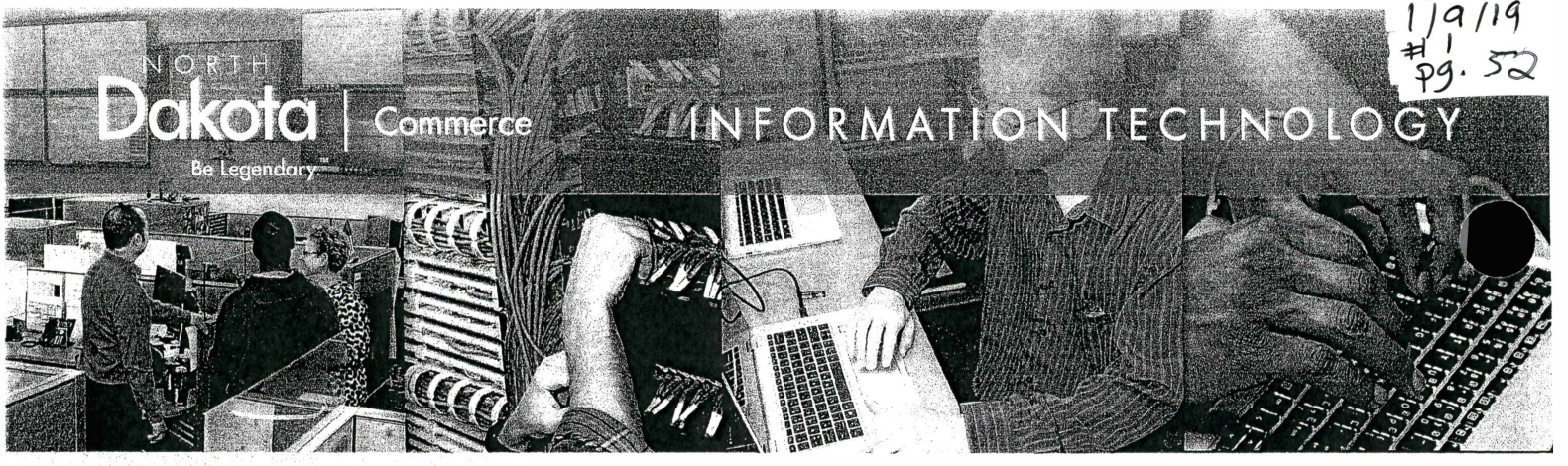

INDUSTRY FACTS

$938 MILLION BROADBAND INVESTMENTS PAST 5 YEARS

75% NORTH DAKOTANS WITH GIGABIT INTERNET ACCESS

21,744 JOBS IN TECHNOLOGY SUBSECTORS

6% OF THE STATE'S GDP

NORTH DAKOTA'S TECHNOLOGICAL PROWESS

Information Technology, as well as technology subsectors, have rapidly become one of North Dakota's largest industries and continue to be a driver for all sectors of the state's economy. In addition, IT is a major center for innovation that stimulates job growth in areas like agriculture, healthcare, energy production and autonomous systems. Job growth in IT has increased by 11% over the past decade where start-up activities have become plentiful. The state's technology subsectors employ approximately 22,000 people across 3,000 businesses, including the nation's second-largest Microsoft campus. In addition, IT and technology contribute approximately $3 billion per year to the state's Gross Domestic Product with annual wages averaging $62,000 per employee. Over the last decade, North Dakota has enjoyed a 27-percent increase in technological applications and is projected to realize 20-30 percent more growth over the next 10 years. This is due to significant cluster development and growth in areas such as mobility (autonomous systems), computer and cyber sciences, and cybersecurity. Also, the state's energy and agriculture industries have become highly integrated with North Dakota based technological firms offering operational efficiencies via sophisticated advanced manufacturing capacity.

CONTRIBUTING GROWTH FACTORS

North Dakota has achieved and sustained growth in the IT sector for several reasons. In 2018, two new data centers were constructed, significantly expanding storage capacity. North Dakota is a national leader in broadband activity with almost $1 billion invested in infrastructure coupled with the state likely becoming the first to achieve one-gigabit connectivity for all school districts. In addition, North Dakota is the first state to adopt the Cyber Sciences Initiative where students will be provided with the technological skills needed to meet future workforce needs. Within higher education, Bismarck State College teamed up with Palo Alto Networks, a global cybersecurity leader, to educate students for high in-demand jobs. At both UND and NDSU, undergraduate and graduate programs are offered within the Research Institute for Autonomous Systems and Computer Sciences College to further machine learning, artificial intelligence, cybersecurity and autonomous systems development. In addition, in December 2018, Governor Burgum announced a $30 million request to create the nation's first Beyond Visual Line of Sight (BVLOS) network in the United States for unmanned systems. As such, North Dakota has the progressive approach, infrastructure, educational institutions and workforce requirements to lead the nation in various IT and technical disciplines.

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DID YOU KNOW

Technology subsectors in North Dakota **employ 22,000 people** across 3,000 businesses, including the nation's second-largest Microsoft campus.

North Dakota is a **national leader in broadband** activity with almost $1 billion invested in infrastructure

IT and technology contribute approximately **$3 billion per year** to the state's Gross Domestic Product

Annual wages in IT average **$62,000**

SMALL COMPANIES WITH AN IMMENSE IMPACT

IT and technologically oriented firms have not only led to job creation but have supported statewide economic diversification while contributing to national and international Intellectual Property commercialization. Emerging technologies in sectors such as energy production, biomedical, UAS/Precision Ag, software development and defense tech are being developed and commercialized in North Dakota as a direct result of North Dakota's unique clusters.

Myriad Mobile (IT Development) — On May 15, 2018, Myriad Mobile received $7 million in individual funding. Myriad Mobile is an enterprise software development company specializing in agtech with a focus on design, development and strategy. The firm creates custom mobile-first software applications and technology platforms and has worked on over 600 projects since 2011. It employees almost 100 people.

Packet Digital (IT and Military Tech Development) — On April 26, 2018, Packet Digital received $9.69 million in individual funding. Packet Digital is a manufacturing company that specifically manufactures and markets circuits for power management in portable devices and embedded systems. The company works with customers in multiple industries including medical devices, consumer, and defense.

Steffes Corporation (Energy Tech) — Developed an Electric Thermal Storage (ETS) system that gains efficiency by taking advantage of off-peak electricity, which is charged at a lower rate since it is consumed during times when demand on the electrical grid is low. With Steffes ETS system's ability to store vast amounts of heat for long periods of time, customers enjoy on-peak performance for an off-peak price.

Baker Boy (Advanced Manufacturing Tech) — Baker Boy is bringing well-paying and highly skilled manufacturing jobs to North Dakota through innovative manufacturing practices driven by new technologies. Production capacity will increase from 5,000 donuts per hour to 22,000, adding approximately $15 million in sales per year.

Harris Corporation (UAS and Precision Ag) — Developed aviation-grade network services specifically for UAS operations which included a risk and safety assessment of UAS detect-and-avoid technology. The UAS BVLOS network will be developed within the Grand Forks-to-Fargo corridor. This technology is the proof-of-concept for a statewide network.

WHAT'S NEXT FOR IT AND TECH

North Dakota is making the requisite investments in infrastructure, K-12 education and in its university system to provide a solid foundation for industry to continue to grow; with projected increases of 20-30 percent in IT and technical positions, North Dakota will be positioned to have the necessary workforce in place to meet demand. To further growth prospects in IT and emerging technologies, the North Dakota Department of Commerce is leading an IP commercialization initiative with the Bank of North Dakota and University System to enable job creation, spinoffs into private industry and clustering of new companies that leverage research in emerging sectors. This will be accomplished through refining current IP commercialization efforts within the University System as well as bringing entrepreneurs, venture capital firms, researchers and industry together to grow this sector.

For more information, contact James Leiman at jleiman@nd.gov

ATTACHMENT 7

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Bonnie Storbakken

From: Lynette McDonald
Sent: Sunday, December 30, 2018 8:05 PM
To: Bonnie Storbakken
Subject: Fw: Board of Medicine Meeting Highlights - November 2018

From: Darin Willardsen <willardsend@horizonvirtual.net>
Sent: Friday, December 28, 2018 10:36 PM
To: Lynette McDonald
Cc: Todd Severnak; Jeremy Skramsted
Subject: RE: Board of Medicine Meeting Highlights - November 2018

Bonnie,
Great to have the conversation with you a few weeks ago about the language pertaining to the prescribing of opioids through telemedicine only if done so as a federal Food and Drug Administration approved medication assisted treatment for opioid use disorder. In our line of work in providing telemedicine to rural hospitals as board certified admitting Internal Medicine physicians, we do see the absolute requirement for the ability to write for these medications on the inpatient unit at the time of admission.
Please reconsider the wording on the current bill to exclude the practice of inpatient medicine on the restrictions for opioid prescription in telehealth patients and providers. Please let me know if I can clarify or provide any further information on this paramount concern.

Thanks,
Darin Willardsen, MD, MBA
CEO - Horizon Virtual
Internal Medicine Hospitalist
willardsend@horizonvirtual.net
C - [redacted]
W - (320) 345-5740

From: Bonnie Storbakken Lynette McDonald
Sent: Tuesday, December 18, 2018 8:59 AM
To: willardsend@horizonvirtual.net
Subject: Board of Medicine Meeting Highlights - November 2018

North Dakota Board of Medicine News Blast:
The Board of Medicine has filed an Agency Bill on Telemedicine for consideration at the 2019 Legislative Session. The Telemedicine Bill attempts to put into law specific language regarding the practice of telemedicine in North Dakota. The Board discussed this at their November meeting and decided to submit the language that was proposed within the Administrative Rules Process. The language can be viewed by clicking here.
November 16, 2018 Board of Medicine Meeting Highlights:

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At the meeting the Board approved 193 physician licenses. Eight (8) stipulations for discipline were approved by the Board. The Board also approved seven (7) pharmacy collaborative agreements.

In addition, the Board listened to a presentation from Adam Peer from the American Association of Physician Assistants regarding the push for Physician Assistants across the nation to remove the supervision requirement for physician assistants. The Board was presented with a draft of language to amend the PA rule in North Dakota along with amendments to the language ensuring that PA's would be required to have two years of supervision after their training is complete and to ensure that PA's will not have the ability to own their own clinic. After the discussion the Board motioned to support this legislation as discussed if it were introduced in the upcoming legislative session.

The Board also listened to a presentation from the Federation of State Medical Boards (FSMB) regarding the services that are available to Boards through the Federation (www.fsmb.org). The FSMB representatives also provided information to the Board regarding the Interstate Medical Licensure Compact (IMLC). For more information on the IMLC, click here. The Board directed Bonnie to provide testimony in support of the IMLC if legislation is introduced in this upcoming legislative session.

As mentioned above, the Board discussed the telemedicine rule that had been passed and the direction from the Administrative Rules Committee to address this type of rule with the full body of the Legislature through an agency bill. The Board voted to have their Executive Secretary draft the Telemedicine Bill using the same language that was proposed to the Legislative Rules Committee.

2019 North Dakota Board of Medicine Meetings:

March 22, 2019
July 19, 2019
November 22, 2019

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But maybe they can change it ahead of time.

Courtney

[redacted]

Courtney Koebele | Executive Director| North Dakota Medical Association
1622 E. Interstate Ave. | Bismarck, North Dakota 58503
[redacted] | 701.223.9476 | ckoebele@ndmed.com | www.ndmed.org

From: Sens, Mary <mary.sens@und.edu>
Sent: Tuesday, December 18, 2018 12:18 PM
To: lmcdonald@ndbom.org; Courtney Koebele <courtney@ndmed.com>
Cc: Barry Ziman (s) [redacted]
Subject: Telemedicine Bill

Thank you for forwarding the proposed Telemedicine bill by the NDBOM for the upcoming legislative session. Please consider an amendment for specialty consultation. Although the "24 hour" exemption covers many consultations; some, including pathology and some oncologic or complex clinical consultations, may require more time and/or review of information. The proposed amendment below would cover this and serve our North Dakota patients while being totally congruent with the spirit and intent of the legislation.

Proposed Amendment Section 2:

(5) An intra-specialty clinical consultation for diagnosis of a patient in this state, provided that both specialists are [redacted]ained in the same specialty and the specialist requesting the consultation is a physician licensed to practice [redacted]edicine in the state.

I am happy to contact the proposed sponsors of this bill if needed. I have copied Courtney as a courtesy as well as Barry Ziman from the College of American Pathologists who is aware of other model legislation and is available to assist as needed. Although this proposed amendment would cover pathology consultations, it is much broader and would include any intra-specialty clinical consultation appropriate and needed for care of North Dakota patients.

Thank you,
Mary Ann

Mary Ann Sens, MD, PhD
Professor and Chair of Pathology
University of North Dakota
School of Medicine and Health Sciences
1301 N Columbia Road
Mailstop 9037 Room W424
Grand Forks, ND 58202-9037

Department Voice: 701-777-2561
Forensic main number: 701-777-1200
[redacted]Departmental Fax: 701-777-3108
[redacted]Direct voicemail: 701-777-2630

mary.sens@ndus.edu

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Bonnie Storbakken

From: Lynette McDonald
Sent: Monday, January 7, 2019 1:32 PM
To: Bonnie Storbakken
Subject: FW: 2019 Legislative Update: Physician Assistant & Telemedicine Bills

FYI

From: richard davis hart <[redacted]
Sent: Saturday, January 5, 2019 8:12 AM
To: Lynette McDonald <LMcDonald@ndbom.org>
Subject: Re: 2019 Legislative Update: Physician Assistant & Telemedicine Bills

Strongly support telemedicine bill. Medical costs can be reduced by technological advances. There are many patients I see who are chronically ill. They could be treated over phone. Unfortunately They clog up a surgical practice where we have real acute problems and not enuf time to take care of these patients and end up working at nite where costs are higher. Chronic fatigue contributes to Doctor burnout problems I know I haven't addressed all the reasons to support this advance but hopefully gave u some new perspectives. Dr. Richard Hart DO FACOS

Sent from my iPhone

On Jan 4, 2019, at 3:36 PM, Bonnie Storbakken <lmcdonald@ndbom.org> wrote:

> LEGISLATIVE UPDATE:
>
> The telemedicine bill will be heard by the Senate Human Services Committee on Wednesday, January 9, 2019 at 9:00 am CT.
>
> The Physician Assistant bill draft was provided to us. It has not received a number or committee assignment at this point but that should be taking place very soon.

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Bonnie Storbakken

From: Courtney Koebele <courtney@ndmed.com>
Sent: Monday, January 7, 2019 12:42 PM
To: Bonnie Storbakken
Subject: Fwd: S.B. 2094: Explanation of the Reasons for Replacing "Deemed"

Courtney Koebele
NDMA
[redacted]

Sent by iphone

From: Michael Mullen Sr. <[redacted]
Sent: Monday, January 7, 2019 12:14:10 PM
To: Courtney Koebele
Subject: S.B. 2094: Explanation of the Reasons for Replacing "Deemed"

Courtney Koebele, Executive Director NDMA
Dear Courtney:
I'm sure the last thing you need late on Monday morning are unsolicited comments from a persnickety curmudgeon on a bill you didn't draft.

[redacted]m referring to S.B. 2094 relating to the practice of telemedicine, which was introduced at the request of the North Dakota Board of Medicine.

This bill contains an inappropriate word, "***deemed***," which in my view should not be used in legislation—even though to my surprise it is not included in a list of words to be avoided in the North Dakota Legislative Drafting Manual. *See* NORTH DAKOTA LEGISLATIVE DRAFTING MANUAL 2019 at 100-101 (the list of words and phrases to avoid using does not include "deem").

To cut to the chase, here is how, in my view at least, S.B. 2094 should be amended:

On page 2, replace line 20 with the following [not in formal amendment style, but showing changes]:

"The practice of medicine is ~~deemed~~ *considered* to occur in the state *where* the patient is located. A practitioner"

More formally the amendments I suggest would be as follows:

On page 2, line 20, replace "deemed" with "considered" and after "state" insert "where"

On page 3, line 24, replace "deemed" with "considered"

On page 4, line 1, replace "deemed" with "considered"

[redacted]

Explanation of the Reasons for Replacing Deemed

The word deemed should be used only if a statute is creating a real legal fiction: treating a thing as something which in the real world it is not—e.g., "for the purposes of this act, a dog is deemed to be a horse."

As used in S.B. 2094, it is not clear that the practice of telemedicine doesn't "occur in the state where the patient is located[,]" North Dakota.

If the drafter of S.B. 2094 insisted on using the word *deemed* to describe a legal fiction, the bill might contain a sentence like this:
"A licensee practicing telemedicine shall be **deemed** to be located in
this state regardless of where the licensee is actually located when practicing telemedicine." *See* Bryan A. Garner, A Dictionary of Modern Legal Usage 254 (2nd ed. 1995) ("[deem] is a FORMAL WORD often used in legislation to create legal FICTIONS").

But "deemed" is not used in the legal fiction sense in S.B. 2094, so it should be replaced with "considered."

The ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT in describing *where* the practice of medicine *occurs* avoids the use of the term "deemed":

"For the purpose of the medical practice act, the practice of medicine is *determined to occur where the patient is located* in order that the full resources of the state are available for the protection of that patient." [Emphasis added.]

See ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT, Section II[C] (Definitions) (Adopted as policy by the Federation of State Medical Boards in April 2015), found at: http://www.fsmb.org/siteassets/advocacy/policies/essentials-of-a-state-medical-and-osteopathic-practice-act.pdf [last viewed Jan. 6, 2019].

As a famous 20th Century author of textbooks and teaching materials on legal and legislative drafting Reed Dickerson advised:

Don't say
Say
deem
consider

The Fundamentals of Legal Drafting by Reed Dickerson 127 (1965); *see also* Montana Bill Drafting Manual 2008, § 2-20, at 24 (same); South Dakota Guide to Legislative Drafting 29 (Rev. 2016) (same); *DRAFTING STYLE MANUAL, Alabama Legislative Drafting Service, Rule 7(h) ("Do not use 'deem' for 'consider.' Use 'deem' only to state that something is to be treated as true even if contrary to fact");* MASSACHUSETTS SENATE LEGISLATIVE DRAFTING AND LEGAL MANUAL, Part I.A.8. (3rd ed. 2003) ("Do not use 'deem' for 'consider'."); Legislative Drafting Style Manual - Utah Legislature, § __ ¶ xii ("A legislative drafter should avoid the word 'deem.' The term 'consider' is generally the appropriate term").

As Matthew Salzwedel a blogger on legal writing noted:

"Deem comes from Old English, and few non-lawyers use it. To take the example of Joe and his grocery shopping [ ], you probably won't hear him say that he "*deems* his grocery store to be the best store in town." Some lawyers, though, use *deem* to create a legal fiction, as in "*the parties deem that they entered into this contract on January 1, 2014*." This usage is minimally defensible." Matthew Salzwedel, on Faux Words of Precision—Part 1 (Sept. 4, 2013), found at:
https://lawyerist.com/faux-words-precision-part-1/ (in 2012 Salzwedel created a site the *Legal Writing Editor*).

And, as Bryan Garner notes in Garner's Modern American Usage, (3rd ed. 2009), *deem* "is a formal word t imparts the flavor of archaism. It frequently displaces a more down-to-earth term such as *consider, think, or judge*." Generally speaking, "no precision is gained from using *deem* in its archaic sense. No judge will penalize a lawyer who uses the *parties consider* or *the parties agree* in its place."

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I hope you appreciate receiving unsolicited advice on arcane issues.

[redacted]est wishes,
Mike

PS—This is how I killed some time on Sunday after snowboarding and before the NFL playoff games. And, after collecting the information I thought I've got to send it to somebody.

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HISTORICAL DOCUMENTS

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Administrative Rules Committee
December 5, 2017

North Dakota Board of Medicine
Bonnie Storbakken, Executive Secretary

Chairman Devlin, members of the Administrative Rules Committee, my name is Bonnie Storbakken I'm executive secretary of the North Dakota Board of Medicine. Thank you for the opportunity to provide testimony regarding rules recently passed by our board.

Please accept the following responses to the questions outlined in the letter I received from Vonette Richter.

1. These rules are not the result of statutory changes made by assembly, except for the PDMP rule which was required to be implemented in 2015 legislation introduced by Representative Kaiser in HB 1149 which required licensing Boards to implement rules regarding participation in the PDMP.

2. These rules are not related to any federal statute or regulation.

3. We followed the rule making procedure as outlined in state law and summarized in the Attorney General's manual for state agencies. Specifically, we published written notice of intent to adopt these rules in all legal newspapers during the week of August 30, 2017. We held public hearing on the rules in our office on Wednesday, September 27, 2017. We held the record open for the required 10 days following the hearing for written and oral comments. The board had a meeting in October to discuss and consider the comments. Process was reviewed by the Attorney General and approved as to its Legality in an opinion dated October 27, 2017.

4. Oral comments were received at the hearing held in September from Teledoc, Sanford Health as well as Dr. Andy McLean. These comments were regarding the telemedicine rule. Oral comments were received from the Attorney General's office that were confirmed through email regarding the PDMP rule. And written comments were received on both the PDMP rule as well as the telemedicine rule. All comments were included within Packet 1 that was sent to the Legislative Council. Additionally, all comments received on the telemedicine rule from the 2015 rulemaking process were also submitted.

5. The major cost of developing and adopting these rules other than staff time was the cost of publication which was $ 2,239.44 for this publication and $2,052.84 for the previous publication done in 2015 which was done for the telemedicine rule only.

6. A brief explanation of each rule and what prompted the rule is included at the end of this testimony.

7. A regulatory analysis was done regarding the telemedicine rule. The result of the regulatory analysis was that it was impossible to calculate the impact of this rule.

8. No small entity analysis was made as the board is exempt.

9. The rules have no fiscal effect.

10. No taking's assessment was required.

11. These rules were not adopted as emergency or interim rules.

Number 6: Brief description of each rule and the reason for enacting each rule.

50-02-02-01 Exceptions to technical requirements on licensure.
This rule was passed by the board after receiving applications from numerous applicants that were just slightly outside of the board's technical requirements to obtain licensure in the state of North Dakota. The board wanted to ensure the ability to license folks who are board-certified and would provide a unique or special contribution to the practice of medicine not readily available elsewhere within the state of North Dakota.

50-02-02.1 The Administrative License
This license was developed when reviewing applicants who had spent the majority of their time in administrative functions and wanted to continue to provide those services but hadn't practiced in some time. The license allows for the administrative function to continue but not allowing patient care. This license is one that has been utilized in other states as well.

50-01-15 Telemedicine
The telemedicine rule attempts to define the practice of telemedicine within the state ensuring that there is a standard of care that must be adhered to and defining how that standard of care is met. The board has been contemplating the rule on telemedicine since prior to 2015. In 2015 the Board approved this draft to move forward through the rule making process. The Board did hold a public meeting and hearing on this rule in 2015 and that process was not approved by the Attorney General's office for lack of proper notice.

The rule has not changed outside of minor corrections in numbering and grammar since it was noticed and reviewed in 2015. The summary of the comments received in 2015 as well as the summary of comments received in 2017 is attached for your review. Some of the comments remain the same and others are new.

In 2015 and in 2017 Teledoc requested less technology specific language seeking the use of a phone call with store and forward technology. The board has received and reviewed these comments twice now and remains dedicated to the current language which requires a like in-person meeting when establishing the licensee-patient relationship. There are a few reasons

that have been discussed by the Board to keep this language. The intent of the Board is to ensure that the standard of care is no different in an in person meeting with your provider than it would be through a telemedicine meeting. If the standard of care would require the provider to look into the patient's ear with an otoscope then that would be expected to be conducted through a telemedicine visit as well using technology and peripherals as necessary. The language in the rule allows for the provider to use their discretion in how to conduct future meetings with an established patient specifically, to allow proper follow up care. Again, the overall intent is to ensure that the standard of care is met for each patient interaction.

Another important issue the Board considered is the responsible stewardship of antibiotics. This discussion has not gone away since the original inception of creating this rule it has only become more emergent. I have also included a Power Point on this subject from Dr. Paul Carson within your materials.

One of the comments that was received by the North Dakota Psychiatric Society was a new comment that was not made in 2015. This comment had to do with our prohibition of opioid prescribing through a telemedicine encounter. The Psychiatric Society has asked that an exception be made for medications used in Medication Assisted Treatment (MAT) such as buprenorphine. Although there was some support for this on the Board it was the decision of the Board not to create this exception. The medication referred to although it can treat opioid addiction it also has the potential to be abused, misused and diverted.

50-05-02 Prescription Drug Monitoring Program

This rule requires every practitioner with a DEA registration number to register with the prescription drug monitoring program and further defines how the prescription drug monitoring program should be utilized within their practice. This rule was based on action taken by the legislature in 2015. HB 1149 introduced by Representative Kaiser required all regulatory boards to require licensed individuals under the boards jurisdiction who prescribe or dispense controlled substances to utilize the prescription drug monitoring program.

I would be glad to try to answer any questions of the committee.
Respectfully submitted,

Bonnie Storbakken
Executive Secretary
North Dakota Board of Medicine

REGULATORY ANALYSIS

Proposed rule chapter 50-02-15, Telemedicine

The North Dakota Board of Medicine has proposed five administrative rules for hearing on September 26, 2017: one dealing with telemedicine, one dealing with administrative licenses, one dealing with special licenses, one dealing with the Physician Drug Monitoring Program (PDMP) and one dealing with the supervising physician for physician assistants. Only the proposed rule dealing with telemedicine requires a regulatory analysis.

The proposed telemedicine rule may have an impact on the regulated community in excess of fifty thousand dollars, although, for the reasons stated, it is not possible to quantify the amount of impact.

1. **Affected classes.** Physicians and physician assistants who wish to practice telemedicine will be affected by the proposed rule. There are no direct costs associated with the rule.

2. **Impact of the rule.** The rule permits the establishment of a patient-physician relationship through acceptable encounters and evaluations that occur with the patient in one location and the practitioner in another. It allows diagnoses and subsequent treatments, with the exception of prescribing opioids for pain management, based on such a telemedicine encounter. This will have a large impact on the regulated community with respect to how they may choose to deliver medical services. It will have a large impact on North Dakota citizens in terms of how they choose to obtain medical care.

The rule specifically excludes the establishment of a patient-physician relationship made only over the telephone or through a static online questionnaire as acceptable forms of telemedicine.

It is not possible to determine the positive economic impact for North Dakota licensed physicians -- who may or may not physically reside in North Dakota – who diagnose and treat patients using approved telemedicine. Nor is it possible to determine the negative economic impact for those North Dakota licensed physicians working for a telemedicine company that chooses to utilize a method of telemedicine that is not acceptable under the rule, that is, telephone or online questionnaire only.

3. **Quantification of data.** It is not practicable to attempt to quantify the impact of the rule. It is dependent on an unknown number of encounters between North Dakota licensed physicians, over half of whom physically practice out of state, and North Dakota citizens. The field of telemedicine is changing rapidly, from more traditional forms, such as remotely reading radiology films, to direct-to-consumer primary care. The nature and costs associated with this type of care cannot be accurately predicted.

4. **Costs and revenues.** There will be a cost of approximately $2,200.00 to implement the rule, primarily for publication costs. There are no other implementation costs. Nor are there identifiable enforcement costs.

5. **Consideration of alternate methods of regulating telemedicine.** The Board studied this issue for over a year and considered key alternatives to this rule. It published proposed policies on its website and requested comments from all licensees and the public regarding the appropriate regulation of telemedicine. It received numerous comments which informed the content of this rule. A list of those submitting comments, as well as the comments themselves, are available.

The board seriously considered many alternatives to the proposed rule, including the requirement of having an intervening health care provider at the site of patient during a remote encounter; regulating the technology required for acceptable telemedicine encounters; prohibiting the prescribing of all controlled substances through a telemedicine encounter; requiring the automatic provision of medical records to telemedicine patients; allowing telephone-only encounters or encounters based only on online questionnaires; allowing video encounters without the use of diagnostic tests or peripherals to be acceptable.

In the end, the board decided to impose a rule stating telemedicine rules must be the equivalent of an in-person evaluation or examination, and use the lab tests and peripheral tools that would be used in an in-person encounter. Diagnosis and treatment could then be done in the practitioner's discretion. It was felt this allowed the benefits of telemedicine to be enjoyed by North Dakota citizens while maintaining a standard of care equivalent to that required of more traditional medical encounters. The one exception was the prohibition of prescribing opioids for pain control through telemedicine, which was done to avoid exacerbating the prescription drug diversion and abuse epidemic currently facing the state and country.

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Summary of oral comments received at the public hearing for proposed rules of the North Dakota Board of Medicine

The public meeting was opened at 9:00 am by Bonnie Storbakken the executive Secretary for the North Dakota Board of Medicine. Nine people attended the hearing, they are listed as follows:

1. Dr. Jason Tibbles representing Teledoc
2. Claudia Tucker representing Teledoc
3. John Ward from Zueger Kermis and Smith representing Teledoc
4. Marnie Walth representing Sanford Health
5. Dr. Chris Meeker representing Sanford Health
6. Dr. Andy McLean representing North Dakota Department of Human Services and UND SM HS
7. Courtney Koeble representing the North Dakota Medical Association
8. Megan Houn representing Blue Cross and Blue Shield of North Dakota
9. Luis San Jose representing himself.

Telemedicine Rule Comments:

1. The comments received from Dr. Andy Mclean were regarding the prescribing section of the telemedicine rule. Dr. McLean states that the section regarding the prescription of opioids may have impact on treatment of opioid use disorders. As such, Dr. McLean suggested an exception to this section for prescribing done for medical assisted treatment. Dr. McLean also provided a written comment reiterating his analysis of the rule.
2. The comments received from the Teledoc representatives stated that they also provided a written comment in the form of a letter but wanted to appear in person to listen and participate in the hearing. The comments from Teledoc were related to the requirement of the use of audio visual in the development of a patient-licensee relationship. They stated that taking care of patients without video is done every day and that patients should have a choice in how they engage in their medical care. They suggested that the use of the standard of care language and less technology specific language would be better as innovation will always outrun technology. Removing the technology specific language would provide for more access as not all folks in North Dakota are in a place that has broad band internet.
3. The representatives from Sanford also centered on the development of the licensee-patient relationship. They stated that this relationship should be established by at least one face to face meeting or an initial video visit. This may allow the physician to uncover more of what is happening with the patient. There is a potential for misdiagnosis due to a lack of information.

No other comments were received at the hearing.

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Summary of Written Comments received on the 2017 Rules Package.
2017

Telemedicine Rule:

Teledoc seeking changes regarding the requirement of a like in person examination specifically, the video requirement.

Sanford Health comments involve changing the language regarding the development of a valid patient relationship. There was support for a like in person examination from Sanford. Specifically, they used two way video or in person examination to establish the patient relationship within their recommended language.

Allergy and Asthma Network objected to the requirement of the use of audio visual technology to establish a patient licensee relationship.

New Benefits who asked for technology neutral language eliminating the requirement for audio visual technology to establish the physician patient relationship.

United Spinal Association who asked for elimination of the requirement of the use of video in establishing the physician patient relationship.

Dr. Andrew McLean seeking an exception for prescribing of buprenorphine products when used for MAT purposes.

North Dakota Psychiatric Society whose comments were seeking an exemption for prescriptions of medication used for medication assisted treatment (MAT).

Dr. Laura Lizakowski objecting to the prohibition of prescription of opiates via telemedicine based on her practice of palliative medicine and management of pain patients with metastatic cancers.

PDMP Comments

Sanford Health seeking to eliminate language from section 3 of the PDMP rule specifically the list of signs that would require the provider to check the PDMP and allowing for more general language to precipitate the requirement for checking the PDMP.

Attorney General

Seeking to add additional items to the list of signs requiring a practitioner to check at the PDMP based on the fact that they would be things readily noticeable by the physician.

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Paul Azure

Objecting to the requirement to report prescriptions to the PDMP based on health care cost.

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TELADOC.

September 20, 2017

Bonnie Storbakken
Executive Secretary
North Dakota Board of Medicine
418 East Broadway, Suite 12
Bismarck, ND 58501

Re: Proposed Rules Relating to Telemedicine Services

Dear Ms. Storbakken:

Teladoc appreciates this opportunity to comment on the North Dakota Board of Medicine proposed rules relating to Telemedicine Services. Telemedicine is dynamic and evolving. Teladoc respects the role of the Board in considering the appropriate rules and clinical practice guidelines that are designed to be protective of public health and maintain high-quality care for patients while permissive of new technological innovations.

Teladoc is the nation's first and largest telehealth platform, delivering on-demand healthcare anytime, anywhere, via mobile devices, a web-based portal, video and interactive audio. We connect our enrollees with our network of more than 3100 board-certified physicians and mental health providers with an average of 15 years of physician experience. These physicians treat a wide range of conditions such as upper respiratory infection, urinary tract infection, influenza and sinusitis. Over 20.1 million enrollees now benefit from access to Teladoc 24 hours a day, seven days a week, 365 days a year. After more than a decade of service and over 2.5 million telehealth visits, Teladoc has yet to be subject to a single malpractice claim. With over 100 proprietary clinical guidelines, NCQA certification and our recent HITRUST certification, nothing is more important to Teladoc than quality health care.

Teladoc telehealth delivery model

Teladoc provides telemedicine services via web-based interactive audio-video visits or interactive audio using asynchronous store and forward technology, as selected by the patient. Teladoc physicians only treat minor, non-emergent, non-recurring medical issues with short-term prescriptions of common medications as may be appropriate to the diagnosis and standard of care. Teladoc physicians, where appropriate, advise the patient regarding whether that patient should seek an in-person consultation with a physician or go to an emergency room. The Teladoc physician may also refer the patient back to his or her primary care physician when appropriate.

Teladoc' s services are only provided to patients through their employer, health-insurance company, state Medicaid plan or hospital system and are not open to the direct-to-consumer market. Only patients who have been appropriately validated through the Teladoc system may make appointments for a telehealth visit with Teladoc physicians.

Prior to a telehealth visit, the patient is required to complete a thorough medical history, including an overview of his or her care, allergies, medications, lab tests, family history, and the name of the

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patient's primary care physician if he/she has one. The patient is then placed in the queue to receive a telehealth visit. There is less than 10 minutes median physician response time. A Teladoc physician licensed in the state where the patient is located must access the patient's medical history/electronic health record and review it prior to being given the patient's contact information to initiate the telehealth visit. The physician verifies the patient's identity, makes appropriate documentation in the patient's medical record, acquires the patient consent to diagnose and treat, establishes a diagnosis, and recommends treatment (where appropriate), all in accordance with the appropriate standard of care.

During a telehealth visit, an array of medical technology is available to appropriately address the patient's concerns. This includes the ability to have a secure videoconference as well as upload medical images and files in real time. The Teladoc electronic platform also allows for easy follow-up contact by the patient or physician at any point, and Teladoc physicians are authorized with patient consent to communicate with the patient's primary care physician whenever necessary or appropriate to ensure continuity of care. The patient's electronic health record ("EHR") is updated after each consultation, is easily accessible to the patient on an ongoing basis, and will be provided to the patient's physicians (including the primary care physician) with the patient's permission.

Significantly, Teladoc physicians do not prescribe DEA-controlled substances, non-therapeutic drugs, lifestyle drugs and certain other drugs which may be harmful because of their potential for abuse.

For emergencies, patients are told to immediately visit their local emergency room, call 911 or our physicians will make the call for the patient.

North Dakota Board of Medicine proposed rule 50-02-15

Teladoc applauds the Board's recognition that telemedicine is a valuable tool that uses technology and innovation to improve access to quality healthcare to the citizens of North Dakota. As the Board contemplates good public policy that removes barriers to access, it is important to note that the standard of care should be the same for telemedicine as it is for traditional in-person medicine. Physicians should use their professional judgement as to whether a telemedicine visit is appropriate and what technology is needed in order to establish a valid physician-patient relationship. Using the standard of care requirement, it is important that the Board use "technology neutral" language. As we know, technology advances are much faster than either the legislative or regulatory processes. As noted in HB 1038 which passed in the 2015 legislature, coverage for telehealth services included such technology neutral language; I cite that portion of the bill below:

> g. "Telehealth":
> (1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site; and that is delivered over a secure connection that complies with the requirements of state and federal laws.

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Accordingly, we submit the following recommendations to 50-02-05-03 that track with best practices on telemedicine policy throughout the country:

> c) Evaluations and examinations required to establish a patient-license relationship. Prior to initially diagnosing or treating a patient for a specific illness or condition, an examination or evaluation must be performed. An examination or evaluation may be performed entirely through telemedicine, if the examination or evaluation is equivalent to an in-person examination. A video examination that utilizes appropriate diagnostic testing and use of peripherals that would be deemed necessary in a like in-person examination or evaluation would meet this standard, the use of interactive audio with asynchronous store and forward technology or audio-video, at the professional discretion of the physician, would meet this standard as would an examination conducted with an appropriately licensed intervening health care provider, practicing with the scope of their profession, providing necessary physical findings to the licensee. An examination or evaluation that consists only of a static online questionnaire or an audio conversation "in isolation" will not be considered to meet the standard of care.

We believe that the citizens of North Dakota should not be disenfranchised from access to affordable, quality healthcare just because they do not have access to broadband internet (needed for audio-video) or do not have a smartphone/computer or who do not have the capability to navigate through a web-based platform. We believe that the best technology should be made available to the patient, but the patient should have the right to choose how he/she accesses the telehealth visit with the physician's discretion.

Nationally, 62 million Americans do not have a primary care provider and we expect a 131,000 physician shortage by 2025. Eighty percent of ER visits are due to a lack of access to primary care. Telemedicine is a tool that will address the access to care issue, along with providing the citizens and businesses of North Dakota a way to decrease their costs for a doctor's visit to treat a simple non-emergent illness.

Thank you again for this opportunity to comment and for your kind consideration.

Sincerely,

Claudia Duck Tucker
Vice President, Government Affairs
Teladoc

cc: Dr. Jason Tibbels, Senior Medical Director, Teladoc
Adam Vandervoort, Chief Legal Officer, Teladoc

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Lynette McDonald

Subject: FW: Rule Comments

From: McLean, Andrew J. [mailto:ajmclean@nd.gov]
Sent: Wednesday, September 27, 2017 10:50 AM
To: Lynette McDonald <LMcDonald@ndbom.org>
Subject: Re: Rule Comments

Hey, Lynette,
Here were my comments to the ND telehealth workgroup. If you need something more formal from me, let me know.
Andy
p.s. at end of week, work e-mail address: andrew.mclean@med.und.edu

50-02-15-04. **Prescribing.** A licensee who has performed a telemedicine examination or evaluation meeting the requirements of this chapter may prescribe medications according to the licensee's professional discretion and judgment, with one exception: Licensees may not prescribe opioids through a telemedicine encounter.

"Issue: This is more restrictive than Federal rules, in that controlled substances may be prescribed via telemedicine by a physician or physician assistant if an in-person evaluation of the patient has been performed by that provider. While caution needs to be taken in the prescribing of controlled substances, limiting an entire class of medication may place an undue burden on individuals, particularly those in rural areas who require medication assisted treatment (MAT) for opioid use disorders.

The recommendation would be to allow telemedicine prescribing of buprenorphine products when used for MAT purposes."

Sent from my iPhone

On Sep 27, 2017, at 10:06 AM, Lynette McDonald <LMcDonald@ndbom.org> wrote:

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SANFORD HEALTH

DELIVERED VIA EMAIL

October 9, 2017

Ms. Bonnie Storbakken
Executive Secretary
North Dakota Board of Medicine
418 E Broadway Ave, Suite 12
Bismarck, ND 58501

RE: North Dakota Board of Medicine Notice of Intent, dated August 24, 2017, TO ENACT ADMINISTRATIVE RULES RELATING TO THE PRACTICE OF TELEMEDICINE AND TO THE ISSUANCE OF ADMINISTRATIVE MEDICAL LICENSES, AND TO ENACT ADMINISTRATIVE RULES RELATING TO PDMP REPORTING REQUIREMENTS, AND TO AMEND AN ADMINISTRATIVE RULE RELATING TO SPECIAL MEDICAL LICENSES, AND TO AMEND ADMINISTRATIVE RULES RELATING TO THE SUPERVISING PHYSICIAN FOR PHYSICIAN ASSISTANTS.

Dear Ms. Storbakken:

Sanford Health respectfully submits this comment in response to the above-referenced notice. We appreciate the opportunity to offer our perspectives on these proposed changes and outline how they might impact the patients we serve across North Dakota. These comments may be supplemented or amended as we gain further understanding of the issues.

1. **Enactment of 50-02-15-01, NDAC, relating to the practice of telemedicine**

   As communicated to your predecessor, Mr. Houdek, Sanford shares the board's concerns for quality preservation as telemedicine becomes increasingly prominent in the delivery of care. It is Sanford's position that the proposed rule provide adequate flexibility to accommodate emerging technology-based care delivery systems and the capable medical judgment of this board's licensees. Accordingly, Sanford urges modifications to the proposed rule that:

   - Define a "valid patient relationship" as one established through meaningful in-person or two-way video engagement;

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- Give greater weight to the medical judgment of providers and the ethical standards to which they are held; and

- Within the context of a valid patient relationship, allow providers the professional latitude to deploy a full range of technological resources in a manner that still satisfies applicable medical standards of care.

Attached for your consideration as *Appendix I* is a redlined version of the proposed rule intended to capture the themes described above.

2. **Enactment of 50-02-02.1, NDAC, relating to the issuance of administrative medical licenses**

At this time, Sanford does not wish to offer comments on this rule.

3. **Amendment to 50-02-02-01, NDAC, relating to special license requirements**

At this time, Sanford does not wish to offer comments on this rule.

4. **Enactment of 50-05-02, NDAC, relating to the PDMP**

Sanford fully supports the promulgation of rules to thoughtfully address the serious issue of opioid abuse in North Dakota. Such efforts are consistent with Sanford's own proactive policies and educational initiatives, which continue to yield encouraging results.

As a dedicated partner in this effort, Sanford urges consideration of the following modifications intended to produce a stronger, clearer, more practical rule:

- Strike and add language to Section 2. A. as follows:

  When a practitioner determines that reported drugs will be prescribed to a patient for a period to exceed 12 weeks, the practitioner, or his or her designee, shall request a PDMP report for that patient ~~and, at minimum, at least semi-annually thereafter~~.

  The purpose of the above change is to promote efficient delegation of PDMP access and to create a simpler, cleaner requirement for PDMP consultation. Elimination of the latter

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provision creates a clear instruction of PDMP access upon every prescription of reported drugs that exceeds 12 weeks.

- Strike and add language to Section 3 as follows:

In addition to those reports requested under paragraph 2, practitioners ~~shall request a PDMP report when it is documented in the prescribing practitioner's medical record for that patient that the patient exhibits signs associated with diversion or abuse, including, but not limited to:~~ prescribing reported drugs shall request a PDMP report when, upon examination of a patient, it is clinically apparent the patient is susceptible to diversion or abuse, or the prescribing practitioner's medical record for that patient reflects a readily discernible pattern of behavior suggesting the same.

~~A. Selling prescription drugs;~~
~~B. Forging or altering a prescription;~~
~~C. Stealing or borrowing reported drugs;~~
~~D. Taking more than the prescribed dosage of any reported drug;~~
~~E. Having a drug screen that indicates the presence of additional or illicit drugs;~~
~~F. Being arrested, convicted or diverted by the criminal justice system for a drug-related offense;~~
~~G. Receiving reported drugs from providers not reported to the treating practitioner; and~~
~~H. Having a law enforcement or health professional express concern about the patient's use of drugs.~~

The purpose of the above change is to more generally summarize the circumstances under which a practitioner should consult the PDMP, whether compelled by clinical observation or information discerned from a patient's medical record. This change places greater weight on a practitioner's medical judgment while still contemplating a wide range of factors. The laundry list of factors contained in the draft rule are not entirely applicable to or practically accessible within a patient's medical record.

- Strike Section 4.

The purpose of the above change is to promote clinical efficiency. It is Sanford's understanding that the PDMP system itself logs practitioner usage and could be consulted in

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the event of a licensee investigation. Should the board see it appropriate to preserve this provision, Sanford recommends adding "or his or her designee" after the word "practitioner" for the same reasons stated under Section 2.A.

5. **Amendment to 50-03-01-03, NDAC, relating to the supervision contract requirements for physician assistants**

   At this time, Sanford does not wish to offer comments on this rule.

6. **Amendment to 54-03-01-05, NDAC, relating to the designation of a substitute primary supervising physician**

   At this time, Sanford does not wish to offer comments on this rule.

Thank you for the opportunity to offer comments. Sanford looks forward to working with you and the board to find the properly balanced approach to these important issues.

Sincerely,

Tim Rave,
Executive Director, Public Policy

APPENDIX I

CHAPTER 50-02-15
TELEMEDICINE

50-02-15-01. Definitions. As used in this chapter,
"Telemedicine" means the practice of medicine using electronic communication, information technologies or other means between a licensee in one location and a patient in another location, with or without an intervening healthcare provider. It includes direct interactive patient encounters as well as asynchronous store-and-forward technologies and remote monitoring.

"Licensee" means a physician or physician assistant licensed to practice in North Dakota. A physician assistant practicing telemedicine from another state is subject to the rules regarding physician supervision, except that supervision may be by a North Dakota licensed physician who is practicing telemedicine in North Dakota from the same state as the physician assistant, and need not be by a North Dakota licensed physician who is physically located in North Dakota.

"Valid patient relationship" means a relationship between a patient and licensee that is established through an initial in-person or two-way video examination or evaluation. For purposes of this chapter, a valid patient relationship created between a patient and licensee extends to all licensees of the same practice group or call coverage group.

50-02-05-02. Licensure. The practice of medicine is deemed to occur in the state the patient is located. Practitioners providing medical care to patients located in North Dakota are subject to the licensing and disciplinary laws of North Dakota and must possess an active No th Dakota license for their profession.

50-02-05-03. Standard of care and professional ethics. Licensees are held to the same standard of care and same ethical standards whether practicing traditional, in-person, medicine or telemedicine. Therefore, the following apply in the context of telemedicine:

a) Scope of practice. Professional ethical standards require all practitioners to practice only in areas in which they have demonstrated competence, based on their training, ability and experience. In assessing a licensee's compliance with this ethical requirement, consideration will be given to board certifications and specialty groups' telemedicine standards.

b) Patient-Licensee relationship. A licensee practic ng telemedicine must establish a valid patient relationship ~~with the patient~~ prior to the diagnosis and/or treatment of a patient. A licensee practicing telemedicine shall verify the identity of the patient seeking care; and disclose, and ensure the patient has the ability to verify, the identity and licensure status of any licensee providing medical services to the patient.

c) Evaluations and examinations required to establish a patient-licensee relationship. Prior to initially diagnosing or treating a patient for a specific illness or condition, an examination or evaluation must be performed. An examination or evaluation may be performed entirely through telemedicine, so long as the use of telemedicine permits the licensee to obtain necessary patient information to evaluate, diagnose and treat the patient in a manner consistent with applicable medical standards of care. ~~if the examination or evaluation is equivalent to an in-person examination. A video examination that utilizes appropriate diagnostic testing and use of~~

~~peripherals that would be deemed necessary in a like in person examination or evaluation would meet this standard, as would an examination conducted with an appropriately licensed intervening health care provider, practicing within the scope of their profession, providing necessary physical findings to the licensee.~~ An examination or evaluation that consists only of a static online questionnaire or an audio conversation will not be considered to meet the standard of care unless a valid patient relationship already exists.

Once a licensee conducts an acceptable examination or evaluation, whether in-person or by telemedicine, and establishes a ~~patient-licensee~~ valid patient relationship, subsequent follow-up care may be provided as deemed appropriate by the licensee, or by a provider designated by the licensee to act temporarily in the licensee's absence.

It is recognized that in certain types of telemedicine utilizing asynchronous store-and-forward technology or electronic monitoring, such as tele-radiology or ICU monitoring, it is not medically necessary for an independent examination of the patient to be performed.

d) Medical records. Licensees practicing telemedicine are subject to all North Dakota laws governing the adequacy of medical records and the provision of medical records to the patient and other medical providers treating the patient.

e) Licensees must have the ability to make appropriate referrals of patients not amenable to diagnosis or complete treatment through a telemedicine encounter, including those patients in need of emergent care, or complementary in-person care.

50-02-15-04. Prescribing. A licensee who has performed a telemedicine examination or evaluation meeting the requirements of this chapter may prescribe medications according to the licensee's professional discretion and judgment, with one exception: Licensees may not prescribe opioids through a telemedicine encounter.

Licensees who prescribe controlled substances, as defined by North Dakota law, in circumstances allowed under this rule, must comply with all state and federal laws regarding the prescribing of controlled substances, and must participate in the North Dakota Prescription Drug Monitoring Program.

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Lynette McDonald

From: Bonnie Storbakken
Sent: Friday, September 22, 2017 9:29 AM
To: Lynette McDonald
Subject: Fwd: proposed rule

Sent from my iPhone

Begin forwarded message:

From: LAURA LIZAKOWSKI <LLIZAKOWSKI@altru.org>
Date: September 22, 2017 at 9:03:21 AM CDT
To: "bstorbakken@ndbom.org" <bstorbakken@ndbom.org>
Subject: proposed rule

I am very concerned about the proposed rule to not allow providers to prescribe opiates via a telemedicine visit. I practice palliative medicine and manage pain of patients with metastatic cancers. Many of these patients are quite ill and weak and are in a lot of pain. Those long car rides can be quite difficult for them when they are having a lot of pain. It's really sad that we are now making blanket rules for all patients who are taking opiates. We've lost sight of compassion for who those patients who are suffering greatly and truly need those medications. I hope their voice is considered in all of this. Thank you.

Dr. Laura Lizakowski

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NORTH DAKOTA
PSYCHIATRIC
SOCIETY

A District Branch of the
American Psychiatric Association

October 9, 2017

Bonnie Storbakken
Executive Secretary
North Dakota Board of Medicine
418 E Broadway Ave, Suite 12
Bismarck, ND 58501

Dear Ms. Storbakken:

On behalf of the North Dakota Psychiatric Society, I would like to offer our support of the Board of Medicine's proposed telemedicine administrative rules, with one suggested change.

The rule as currently written would require an in-person visit for every prescription of medication used for Medication Assisted Treatment (MAT). Medication such as Buprenorphine is technically an opioid, and therefore, under the current draft of the rules, would require an in-person visit every time it is prescribed. This may act as a disincentive for follow up visits if every visit to obtain medication must be in person.

Telemedicine, a key innovation in support of health care delivery reform, is being used in initiatives to improve access to care, care coordination and quality, as well as reduce the rate of growth in health care spending. Patients in rural areas of North Dakota have to drive long distances to get to a treatment center or to see an addiction specialist for medication-assisted treatment. Telemedicine could reduce the burden of this barrier.

The North Dakota Psychiatric Society supports policies that carefully regulate the adoption of telemedicine, while still allowing physicians to more easily and readily connect to their patients and facilitate consultations through these technologies. The proposed rules, with the amendment with regard to MAT, would accomplish this.

Thank you for your leadership on this issue.

Sincerely,

Emmet Kenney, MD
President, ND Psychiatric Society

1622 East Interstate Avenue • Bismarck ND 58503-0512 • 701-223-9475 • Fax: 701-223-9476

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Allergy & Asthma NETWORK

8229 Boone Boulevard, Suite 260, Vienna VA 22182 · 800.878.4403 · AllergyAsthmaNetwork.org

October 9, 2017

North Dakota Board of Medicine
418 E. Broadway Avenue, Suite 12
Bismarck, North Dakota 58501

Re: Proposed rules pertaining to telemedicine

Dear Members of the North Dakota Board of Medicine:

Allergy & Asthma Network supports telemedicine legislation and regulations that maximize allowable technologies and enable patients to have greater access to high-quality care. As the leading national nonprofit dedicated to protecting and improving the health of people with asthma, allergies and related conditions, we believe progressive policies regarding telemedicine are essential to fulfilling that goal.

In its current form, proposed regulation 50-02-15 inhibits North Dakotans ability to utilize telemedicine services for affordable, convenient care by including a medically-unnecessary provision requiring the use of audio-visual technology to establish a patient-license relationship. A high-speed Internet connection is needed to support streaming video, and many North Dakotans lack access to such broadband Internet service.

Physicians who deliver care through telemedicine should be held to the same standards as they would be if they were treating a patient in an office. Many patients who suffer from allergies, especially those with allergy-related skin conditions, would benefit from greater and more convenient access to a physician. For patients with chronic respiratory conditions like asthma and COPD, telemedicine would be an effective way to provide disease education and improved disease management. This is particularly true in North Dakota's many rural areas, where visiting a physician's office could require traveling lengthy distances through adverse weather conditions.

We believe telemedicine functions as a complement to existing healthcare resources by increasing access to affordable medical treatment. Allergic reactions and related conditions can occur at any time, and patients should have the option to pursue treatment through telemedicine rather than traveling to a hospital's emergency room in the middle of the night.

We respectfully request that the Board remove the audio-visual mandate from the proposed regulation. Thank you for your attention to this matter.

Sincerely,

Tonya A. Winders

Tonya Winders
President and CEO

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new benefits
creating advantage.

October 6, 2017

VIA EMAIL

North Dakota Board of Medicine
418 E Broadway Ave, Suite 12
Bismarck, ND 58501

Dear Members of the Committee:

I am writing on behalf of New Benefits to request that the proposed telemedicine regulations (Rule 50-02-05-03) before you be amended to allow the patient-license relationship to be established via interactive audio as well as through video. We believe the state should create telemedicine policies that preserve consistent standards and allow physicians to use their knowledge and experience in deciding whether to use modern technology to provide care, without narrowly defining allowable technologies.

For more than a decade, we have offered telemedicine services through Teladoc to our members. Although New Benefits is headquartered in Texas, our presence in North Dakota is substantial. We work with clients such as MBI Energy Services, Cracker Barrel, and Red Lobster, as well as a number of small businesses and school systems. We connect North Dakota residents with North-Dakota licensed physicians, who provide affordable, high-quality treatment of common, non-emergency ailments, and we have received virtually no complaints. Our experience is telemedicine provides patients with high-quality care that is safe, secure, timely and cost-effective.

My hope is that the Board will incorporate technology neutral language into rule 50-02-05-03 which does not require audio-visual technology to establish the physician-patient relationship via telemedicine.

This one change will position North Dakota to take advantage of telemedicine to address the significant areas of the state currently medically underserved and provide employers with a much-needed tool to manage health care costs.

I would be pleased to answer any questions you may have about our experience with telemedicine and can be reached at 1-800-800-8304 x1615.

Sincerely,

Joel Ray

Joel Ray, CEO

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United Spinal Association
www.unitedspinal.org

October 13, 2017

North Dakota Board of Medicine
418 E Broadway Ave, Suite 12
Bismarck, ND 58501

Re: Chapter 50-02-15 and the use of telemedicine

Dear Members of the Board:

United Spinal Association writes to submit public comments requesting that that the language in draft regulation Chapter 50-02-15 be amended. We understand the formal comment period has just passed, but we hope that our organization's views will be considered at the board meeting next week as you take up the issue of telemedicine. Specifically, amending the restrictive language carving out allowable technology in telemedicine will allow the state of North Dakota to maximize expanded access to healthcare for people with disabilities through telemedicine. United Spinal Association supports public policies to promote and improve the quality of life for individuals with spinal cord injuries and diseases.

United Spinal Association is the largest disability-led national non-profit organization founded by paralyzed veterans in 1946 and has since provided service programs and advocacy to improve the quality of life of those across the life span living with spinal cord injuries and disorders (SCI/D) such as multiple sclerosis, amyotrophic lateral sclerosis (ALS), post-polio syndrome and spina bifida. United Spinal represents over one million individuals with spinal cord injuries and disorders, over 50 chapters, over 100 rehabilitation hospital members and close to 200 support groups nationwide. Throughout its history, United Spinal Association has devoted its energies, talents and programs to improving the quality of life for these Americans and for advancing their independence. United Spinal Association is also a VA-recognized veterans service organization (VSO) serving veterans with disabilities of all kinds.

United Spinal Association respectfully requests the Committee amend draft Chapter 50-02-15 to insert language in Section 3. Subsection (c) to explicitly allow the use of video in establishing the physician-patient relationship. The current requirement for audio-visual connections in establishing this relationship creates a barrier to access and removes another avenue for individuals with disabilities to obtain quality intervention via telemedicine.

Telemedicine is a valuable tool for meeting the needs of North Dakotans, particularly those with disabilities, and United Spinal Association strongly supports technology-neutral telemedicine regulations for the purpose of improving public access to high-quality health care. For people in rural areas and those living with spinal cord injuries or other physical disabilities, obtaining in-person care can be a difficult process.

While it is important that telemedicine providers be regulated to protect the public, it is equally important that policies not be designed to impede access. With the requested amendments, the state's telemedicine regulations would ensure that North Dakotans have greater access to medical care from providers that comply with federal and state requirements. If you have any questions, please do not hesitate to contact Jasey Cárdenas, Senior Policy Associate, at jcardenas@unitedspinal.org or (202) 556-2076, x7104.

Sincerely,
Alexandra Bennewith
Alexandra Bennewith, MPA
Vice President, Government Relations

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Lynette McDonald

From: Bonnie Storbakken
Sent: Friday, October 13, 2017 4:10 PM
To: Lynette McDonald
Subject: Fwd: United Spinal Association Comments on Chapter draft regulation 50-02-15
Attachments: image001.png; ATT00001.htm; United Spinal Association - ND Reg Chapter 50-02-15.pdf; ATT00002.htm

We may want to note that receipt of these was past our deadline but include anyway.

Sent from my iPhone

Begin forwarded message:

From: Jasey Cardenas <jcardenas@unitedspinal.org>
Date: October 13, 2017 at 3:17:36 PM CDT
To: "bstorbakken@ndbom.org" <bstorbakken@ndbom.org>
Cc: Alexandra Bennewith <ABennewith@unitedspinal.org>
Subject: United Spinal Association Comments on Chapter draft regulation 50-02-15

Hello,

United Spinal Association would like to submit our comments on draft regulation Chapter 50-02-15. We understand the formal comment period has just passed, but we hope that our organization's views will be considered at the board meeting next week as you take up the issue of telemedicine.

We are requesting that that the language in draft regulation Chapter 50-02-15 be amended. Specifically, amending the restrictive language carving out allowable technology in telemedicine will allow the state of North Dakota to maximize expanded access to healthcare for people with disabilities through telemedicine.

Please let me know if you have any questions. Have a great weekend!

About United Spinal Association:

United Spinal Association is the largest disability-led national non-profit organization founded by paralyzed veterans in 1946 and has since provided service programs and advocacy to improve the quality of life of those across the life span living with spinal cord injuries and disorders (SCI/D) such as multiple sclerosis, amyotrophic lateral sclerosis (ALS), post-polio syndrome and spina bifida. United Spinal has over 49,000 members and represents over one million individuals with spinal cord injuries and disorders, over 50 chapters, over 100 rehabilitation hospital members and close to 200 support groups nationwide. Throughout its history, United Spinal Association has devoted its energies, talents and programs to improving the quality of life for these Americans and for advancing their independence. United Spinal Association is also a VA-recognized veterans service organization (VSO) serving veterans with disabilities of all kinds.

Thank you,

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Jasey Cárdenas, Senior Policy Associate
United Spinal Association

1660 L Street NW, Suite 504
Washington, DC 20036
Office: 202-556-2076 ext. 7104 Fax: 202-223-2380
E-mail: jcardenas@unitedspinal.org Web: www.unitedspinal.org

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Lynette McDonald

From: Bonnie Storbakken
Sent: Monday, September 25, 2017 10:48 AM
To: Lynette McDonald
Subject: Fwd: Follow up from our discussion yesterday.

Not sure I sent this to you. This is the official comment of the Attorney General.

Sent from my iPhone

Begin forwarded message:

From: "Seibel, Troy T." <tseibel@nd.gov>
Date: September 22, 2017 at 10:33:53 AM CDT
To: Bonnie Storbakken <BStorbakken@ndbom.org>
Subject: RE: Follow up from our discussion yesterday.

Bonnie,

Yes, I think that accurately reflects what we discussed. Thanks.

Troy T. Seibel
Chief Deputy Attorney General
Office of Attorney General
600 E. Boulevard Ave., Dept. 125
Bismarck, ND 58505
701-328-2210
tseibel@nd.gov

From: Bonnie Storbakken [mailto:BStorbakken@ndbom.org]
Sent: Wednesday, September 20, 2017 2:34 PM
To: Seibel, Troy T. <tseibel@nd.gov>
Subject: Follow up from our discussion yesterday.

Hello Troy,
I wanted to clarify the official comments From the Attorney General regarding our PDMP rule before they are added to the comments for review by our board.

It is suggested that the Board consider adding the following language because they would be indicators that prescribers would notice and may be suggestive of an issue of one type or another regarding scheduled medications.

This language should be added to the list under section 3.

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1. Violating any prescribing agreement with the physician;
2. Frequently requests early refills of a reported drug for any reason;
3. Appears impaired or excessively sedated to the physician in any patient encounter;
4. Has a history of drug abuse or dependency.

Does this accurately reflect the comments that were intended to be considered?

Thank you,
Bonnie

Bonnie Storbakken
Executive Secretary
North Dakota Board of Medicine
418 East Broadway Ave.
Bismarck, ND 58501

(701)328-6500

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Bonnie Storbakken

From:	info@ndbom.org
Sent:	Tuesday, September 5, 2017 6:06 AM
To:	Bonnie Storbakken
Subject:	Contact Form Submission

Contact Form Submission: Please login to view at https://www.ndbom.org/admin/cgi-bin/contactadmin.pl.

www.ndbom.org/admin/cgi-bin/contactadmin.pl?action=display&contact_id=2798

Submitted values
Name = Paul Azure
Address = Wahpeton
City = Wahpeton
State = ND
Zip = 58075
Phone = 7014034898
Email = paulazure@hotmail.com
Comments = Trying to comment on the administration rules butt could not find the phone number that was supposed to be listed.Will make my comments here,if that is not acceptable call me.I question 50-05.02 reporting medication, and I ask that the full board review this rule and consider the effect this will have when the Congress eliminates federal health care.the cost of the uninsured to health care is going to have to come down or civil unrest and riots like you have never seen will start to happen.Perhaps this board should be eliminating rules and restrictions instead of making more.again I ask that the board consider the outcome of all of the proposed rules ,with the effect they will have on the uninsured population that will have to pay cash for their health care

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TELEMEDICINE RULE COMMENT

Attached are the rules comments we received following our public hearing on October 12th. The comment period ended October 23rd under law, but I've included all comments received, whether they arrived by that date or not.

Some, such as the ND Psychiatric Assn., ND Board of Pharmacy, Health Partners, Dr. Andy McLean, supported the rule as written.

There was a consistent theme for those suggesting changes and it dealt with follow-up care and on-call physicians within a group. Sometimes we get very close to an issue and, perhaps, what seemed pretty clear to me when drafting this rule may not have been clear to others. At any rate, I've drafted an additional paragraph to the rule that makes it clear that 1) follow up care, after a physician-patient relationship is established by the first examination or evaluation (in person or telemedicine), may be done in any way deemed appropriate by the physician or physician assistant. This would allow follow-up phone calls, emails, etc., which I know the board does not intend to prohibit; and 2) on call providers designated by a licensee would be covered by this, as well as the treating provider. I think this covers the objections listed by most of the commenters.

A suggestion by Teladoc, that we change the language and allow a phone call with asynchronous store and forward technology, is not clear to me, as I don't understand what that asynchronous store and forward material would be. Usually, that term is used to describe items such as radiology images, but I don't think that's what Teladoc means. They will be at the hearing, so perhaps we can get clarification on the point. Their language would greatly expand the use of just audio calls, as opposed to our standard language requiring a video component.

ATTORNEY GENERAL

Chairman Devlin called on Mr. Randy Miller, Executive Director, North Dakota Lottery, for testimony (Appendix C) regarding rules adopted by the Attorney General. Mr. Miller said rules are necessitated by the termination of the game, Hot Lotto, and its replacement, Lotto America.

STATE ELECTRICAL BOARD

Chairman Devlin called on Mr. Scott Porsborg, Special Assistant Attorney General, State Electrical Board, for testimony (Appendix D) regarding rules adopted by the State Electrical Board.

In response to a question from Representative Koppelman, Mr. Porsborg said it takes about 2 years to complete the required 576 hours of apprenticeship training classes.

GAME AND FISH DEPARTMENT

Chairman Devlin called on Mr. Scott Peterson, Deputy Director, Game and Fish Department, for testimony (Appendix E) regarding rules adopted by the Game and Fish Department. Mr. Peterson said the rules redefine legal live bait. He said this change eliminates the need for bait vendors who handle only terrestrial live bait to be licensed.

DEPARTMENT OF HUMAN SERVICES

Chairman Devlin called on Mr. Jonathan Alm, Legal Counsel, Department of Human Services, for testimony (Appendix F) regarding rules adopted by the Department of Human Services.

In response to a question from Representative Koppelman, Mr. Jim Fleming, Director, Child Support Division, Department of Human Services, said the guidelines are based on income. He said one of the deductions allowed in calculating net income is the cost of health insurance premiums. He said increasing health insurance premiums will have a corresponding effect on the amount of child support paid to an obligee.

Mr. Fleming said the change to the child support guidelines for those obligors with less than $700 per month in net income was done with the child support obligations of inmates in mind. He said eliminating or reducing the child support obligations of inmates allows an inmate to be released with a clean slate.

In response to a question from Senator Kilzer, Mr. Alm said the Department of Human Services is working with the Attorney General's office to develop a bill draft regarding a Medicaid fraud unit.

NORTH DAKOTA BOARD OF MEDICINE

Chairman Devlin called on Ms. Bonnie Storbakken, Executive Secretary, North Dakota Board of Medicine, for testimony (Appendix G) regarding rules adopted by the North Dakota Board of Medicine.

In response to a question from Senator Heckaman, Ms. Storbakken said 2015 legislation required licensing boards to adopt rules regarding participation in the prescription drug monitoring program. She said the Board of Medicine was awaiting the adoption of federal regulations before the board could finalize its rules.

In response to a question from Representative Koppelman, Ms. Storbakken said during the rules process, the Board of Medicine consulted with the Board of Nursing and the Board of Pharmacy. She said those boards have completed their rules on the prescription drug monitoring program.

In response to a question from Senator Anderson, Ms. Pam Sagness, Director, Behavioral Health Division, Department of Human Services, said Dr. Andrew McLean provided comments at the hearing regarding narcotic prescribing via telemedicine. She said the state did not have any opioid treatment providers in 2015. She said it is important to have further discussion and find solutions. She said access to the drugs used to treat opioid disorder should not be limited.

In response to a question from Representative Koppelman, Ms. Sagness said to prohibit the prescribing of drugs via telemedicine is too broad of a stroke since the treatment for opioid addiction includes drugs that are considered opioids.

Chairman Devlin called on Mr. John Ward, Teladoc. Mr. Ward introduced Dr. Donna Campbell, who is a member of the Texas Senate. Dr. Campbell provided testimony (Appendix H) regarding the telemedicine rules adopted by the North Dakota Board of Medicine.

In response to a question from Senator Anderson, Dr. Campbell said under Teladoc protocol, the doctor has the patient's record in view during the consultation. The doctor also may use high-definition photographs, and, if needed, video. She said telemedicine is not for complicated medical problems; however, a broad range of conditions can be handled by telemedicine. She said the doctor has the option of referring the patient to urgent care, the patient's primary care physician, or to an emergency room.

In response to a question from Representative Koppelman, Dr. Campbell said the lack of broadband access in some areas would make a required video consultation difficult for some patients. She said many people may not be technology savvy enough to use the equipment necessary for a video consultation.

In response to a question from Senator Heckaman, Dr. Campbell said the rule requiring the initial consultation to be conducted via video is arbitrary and capricious. She said a medical condition that creates the need for a second consultation may be unrelated and have no connection to the first visit with video.

In response to a question from Senator Anderson, Dr. Campbell said once the patient relationship is established, it is forever.

Chairman Devlin called on Dr. Jason Tibbels, Teladoc, for testimony regarding the telemedicine rules. Dr. Tibbels said physicians use professional judgment to make an informed decision regarding the care of the patient. He said that duty to make an informed decision is the same regardless of whether the consultation is done in person or via telemedicine. He said telemedicine is not a cure-all for all cases. He said the standard of care is the same whether it is the patient's 1st consultation or the 20th.

In response to a question from Senator Anderson, Dr. Tibbels said for telemedicine to be effective, the rules must use technology-neutral language. He also said the sharing of information is critical.

In response to a question from Senator Heckaman, Dr. Tibbels said Teladoc does not prescribe any controlled substances. However, he said, the treatment of opioids requires some prescribing of controlled substances. He said in his personal opinion, the opioid epidemic is huge and telemedicine should be permitted to be used to treat an epidemic.

Chairman Devlin called on Ms. Claudia Tucker, Vice President Government Affairs, Teladoc, for testimony (Appendix I) regarding the telemedicine rules. She said Teladoc is a very collaborative company. She said the company would be willing to participate in a database for the sharing of information.

In response to a question from Representative Koppelman, Ms. Tucker said Teladoc's issue with the Board of Medicine's telemedicine rule is the rule is not technology neutral.

Chairman Devlin said the committee was emailed letters regarding the rules from the Allergy & Asthma Network (Appendix J), The ERISA Industry Committee (Appendix K), AARP North Dakota (Appendix L), and the United Spinal Association (Appendix M).

It was moved by Senator Poolman, seconded by Representative Koppelman, and carried on a roll call vote to hold over to the next meeting the North Dakota Board of Medicine's rules on telemedicine on pages 90-91 of Supplement 367. Representatives Devlin, Boehning, Boschee, Koppelman, Louser, Pyle, Seibel, Toman, and Weisz and Senators Anderson, Armstrong, Heckaman, Kilzer, Klein, Poolman, and Rust voted "aye." No negative votes were cast.

STATE BOARD OF INDIAN SCHOLARSHIPS

Chairman Devlin called on Ms. Brenda Zastoupil, Director, Financial Aid, North Dakota University System, for testimony (Appendix N) regarding rules adopted by the State Board of Indian Scholarships.

In response to a question from Representative Boehning, Ms. Zastoupil said recipients of the scholarship must be North Dakota residents. She said the ability to provide documentation to prove eligibility has not been a problem.

STATE DEPARTMENT OF HEALTH

Chairman Devlin called on Mr. Dale Patrick, Radiation and Asbestos Control Program, State Department of Health, for testimony (Appendix O) regarding rules adopted by the State Department of Health.

In response to a question from Representative Boehning, Mr. Patrick said the department is notified of any repeals or changes to federal rules which may affect the department's rules.

ATTACHMENT 2a

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Testimony of Bonnie Storbakken, Executive Secretary of the North Dakota Board of Medicine

Hello Chairman Devlin and members of the Administrative Rules Committee. My name is Bonnie Storbakken. I am the Executive Secretary for the North Dakota Board of Medicine. I am here today to discuss with you our telemedicine rule that was held over at your last meeting.

If you recall there was discussion at your meeting in December that there were a number of comments that were received regarding the request to allow the prescription of opioids through telemedicine for medication assisted treatment (MAT) purposes. It was the bulk of comments received pertaining to this issue that motivated us to hold the rule over to give our board an opportunity to review and fully consider these comments.

The second issue that was discussed at your meeting was the video requirement in establishing the Patient-Licensee Relationship. Additional comments regarding this issue were also received by the Administrative Rules Committee as well as by the Board. The Board reviewed the comments that were provided on this issue as well.

It is my intention to provide you with an overview of the action that was taken by our board after the December 5th Administrative Rules Committee meeting and help walk you through the changes that have been made to the rule. Once I finish with this I will introduce Dr. Brenda Miller to you who will provide a little more background of the discussions that have been had by our board regarding the requirements within the rule to establish a Patient-Licensee Relationship.

The actions taken by the NDBOM after the December Administrative Rules Committee Meeting:

1. The Board had a telephone conference meeting at which they appointed a telemedicine committee with decision making authority to assist with the review and possible amendment of the telemedicine rule.
2. The telemedicine committee met on January 4th and addressed the two main issues that were discussed at the Administrative Rules Committee Meeting:
    a. The Patient-Licensee Relationship: the committee felt this issue had been discussed by the full board and the decision of the board was to continue to require the three options under the rule to establish the patient-licensee relationship. They did not agree with the comments seeking to eliminate the language regarding the interactive video examination.
    b. The Prescribing of opioids for MAT purposes: the committee discussed this issue and thought that the rule should be amended to allow for this exception. The committee felt it was necessary to have clear language to allow for this exception to treat those with opioid addictions while still maintaining their commitment to assisting with the opioid issues currently facing our state.

   c. The committee directed Bonnie to work with the parties present to develop language for the opioid exception. The committee also directed Bonnie to work with legal counsel to ensure the current language regarding the Patient-Licensee Relationship was as clear as possible.
   d. Additional comments were received and reviewed at this meeting including those comments received by your committee at the December meeting.
3. The telemedicine committee met again on February 9 to go over the language changes to the rule made by myself in consultation with our legal counsel and in consideration of the suggested changes by the Department of Health as well as the Association.
   a. The committee approved the bulk of amendments made to the rule and directed Bonnie to submit the final draft to the Administrative Rules Committee.
   b. Additional comments were received and reviewed by the committee at this meeting
4. The telemedicine committee met again on March 2 to discuss additional comments that Bonnie had received regarding language in the rule.
   a. The committee made two changes to the language at this final meeting. One change to its definition of telemedicine and one change to the numbering and formatting of the Patient-Licensee Relationship within the definitions section based on comments received.

Summary of Changes made to the Telemedicine Rule:

1. 50-02-15 The first change you see adds a statement to the definition of telemedicine to ensure that everyone understands that asynchronous store-and-forward technology does not mean patient supplied information only. This change was made after reviewing a comment received from CTel (Center for Telehealth and e-Health Law) which stated that some states were dealing with companies who were using only patient supplied information such as a questionnaire and defining it as asynchronous store-and-forward technology. The telemedicine committee felt this interpretation did not fit within their intended definition of asynchronous store-and-forward technology so this sentence was added,
2. 50-02-15 The second significant change made was to provide a definition of the Patient-Licensee Relationship in a clear bulleted fashion within the definitions section of the rule.
   a. This was done to try to be as clear as possible what it takes to establish the patient licensee relationship. There seemed to be an impression from many of the comments heard that video was the only way to establish a patient-licensee relationship.
   b. There was also a change in the language that defined what would not qualify as establishing a patient licensee relationship. The committee removed the word

static in front of the online questionnaire as it appeared through some verbal comments and questions received that there would be use of a drop down or branching questionnaire to establish the patient licensee relationship.

3. 50-02-15-03 (b) was changed to avoid confusion with the definition of patient licensee relationship. This section really went to describing the ability of the patient and provider to be able to verify the identity of each other.
4. 50-02-15-03 (c) this was changed to make clear how examinations must be conducted to establish a patient licensee relationship by referring to the definition.
    a. The subparagraph which allowed for follow up care to be done by examination at the discretion of the provider was changed to ensure that all would understand this was intended to allow for follow up care. Some of the comments seemed demonstrate a belief that the requirement to use video was only for the first visit and therefore arbitrary. The telemedicine committee wanted to ensure that follow up care would be permitted the same as it would be in most facilities. The committee wanted licensees to use their discretion on future visits once the patient-licensee relationship was established to the same degree utilized by licensees in a traditional medicine setting.
    b. The language regarding the exception to an independent examination was amended to make it clear which types of situations would not require an independent examination of the patient.
5. 50-02-15-03 (d) Medical records. We thought this change was needed to make clear what the expectation of records is to all licensees.
6. 50-02-15-04 Prescribing. There was a change in the language that prohibited the prescription of opioids. This language was proposed by the Department of Health and approved by the committee. The language you see today allows for prescription of opioids only within Medication Assisted Treatment (MAT) situation. This allows for the intent to limit the prescription of opioids as well as provide treatment to those with opioid addictions.

Attachments

1. Amended Telemedicine Rule
2. Additional comments that have been considered including those comments submitted to the Administrative Rules Committee in December
3. Additional References
    a. North Dakota Department of Human Services Medical policy regarding Telemedicine which requires face to face visual contact between the practitioner and patient in order to be reimbursed.
    b. CTel article entitled, "Telemedicine: Prescribing and the Internet". This article states that at the time of the article publication that 41 states and one territory required a physician to conduct an in-person or face-to-face exam of the patient before prescribing medication using telemedicine.

c. Public Health Law article entitled "Prescription Drug Physical Examination Requirements".
d. Joint Statement on Antibiotic Resistance from 25 National Health Organizations and the Centers for Disease Control and Prevention
e. CDC Encourages Safe Antibiotic Prescribing and Use

4. Testimony of Dr. Brenda Miller

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ATTACHMENT 1

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CHAPTER 50-02-15
TELEMEDICINE

50-02-15. Definitions. As used in this chapter,
"Telemedicine" means the practice of medicine using electronic communication, information technologies or other means between a licensee in one location and a patient in another location, with or without an intervening healthcare provide. It includes direct interactive patient encounters as well as asynchronous store-and-forward technologies and remote monitoring. Asynchronous store-and-forward technology is not patient only provided information.

"Licensee" means a physician or physician assistant licensed to practice in North Dakota. A physician assistant practicing telemedicine from another state is subject to the rules regarding physician supervision, except that supervision may be by a North Dakota licensed physician who is practicing telemedicine in North Dakota and need not be by a North Dakota licensed physician who is physically located in North Dakota.

"Patient-Licensee Relationship" means a relationship between a licensee and a patient established by any of the following means:

1. A face to face examination/evaluation of the patient by the licensee, or
2. An interactive video examination that utilizes appropriate peripheral and diagnostic testing, or
3. An examination conducted with an appropriate licensed intervening healthcare provider practicing within the scope of their profession and providing necessary physical findings to the licensee, and
4. All examinations or evaluations should be the equivalent to an in -person examination, and
5. The following will not be defined as establishing a patient-licensee relationship:
    i. An examination or evaluation that consists only of online questionnaire, audio only conversation, email only and or electronic communication only, or facsimile communication only.

General Authority: 28-32-02, NDCC
Statute Implemented: 43-17, NDCC

50-02-15-02. Licensure. The practice of medicine is deemed to occur in the state the patient is located. Practitioners providing medical care to patients located in North Dakota are subject to the licensing and disciplinary laws of North Dakota and must possess an active North Dakota license for their profession.

General Authority: 28-32-02, NDCC
Statute Implemented: 43-51-02 NDCC; 43-17, NDCC

50-02-15-03. Standard of care and professional ethics. Licensees are held to the same standard of care and same ethical standards whether practicing traditional, in-person, medicine or telemedicine. Therefore, the following apply in the context of telemedicine:

a) Scope of practice. Professional ethical standards require all practitioners to practice only in areas in which they have demonstrated competence, based on their training, ability and

experience. In assessing a licensee's compliance with this ethical requirement, consideration will be given to board certifications and specialty groups' telemedicine standards.

b) ~~Patient-Licensee relationship~~Verification requirements. A licensee practicing telemedicine must establish a valid ~~relationship with the patient~~patient-licensee relationship prior to the diagnosis and/or treatment of a patient. A licensee practicing telemedicine shall verify the identity of the patient seeking care; and disclose, ~~and ensure the patient has the ability to verify~~, the identity and licensure status of any licensee providing medical services to the patient. The patient must have the ability to verify the identity and licensure status of any licensee providing telemedicine services to the patient.

c) ~~Evaluations and examinations required to establish a p~~Patient-~~l~~Licensee ~~r~~Relationship. Evaluations and examinations. Prior to initially diagnosing or treating a patient for a specific illness or condition, an examination or evaluation must be performed. An examination or evaluation may be performed entirely through telemedicine, if the examination or evaluation is equivalent to an in-person examination as defined under the "Patient-Licensee relationship". ~~A video examination that utilizes appropriate diagnostic testing and use of peripherals that would be deemed necessary in a like in-person examination or evaluation would meet this standard, as would an examination conducted with an appropriately licensed intervening health care provider, practicing within the scope of their profession, providing necessary physical findings to the licensee. An examination or evaluation that consists only of a static online questionnaire or an audio conversation will not be considered to meet the standard of care~~.

Once a licensee conducts an acceptable examination or evaluation, whether in-person or by telemedicine, and establishes a patient-licensee relationship, subsequent follow-up care may be provided as deemed appropriate by the licensee, or by a provider designated by the licensee to act temporarily in the licensee's absence. If three or more years passes between the initial evaluation or examination and consistent care has not been provided by the licensee, another examination evaluation under this rule must be conducted prior to additional diagnosis and or treatment.

It is ~~recognized that in certain types of telemedicine utilizing asynchronous store-and-forward technology or electronic monitoring, such as tele-radiology or ICU monitoring, it is~~ not medically necessary for an independent examination of the patient to be performed in certain types of telemedicine that utilize asynchronous store-and-forward technology or electronis monitoring such as teleradiology or electronic ICU monitoring.~~:~~

d) Medical records. Licensees practicing telemedicine are subject to all North Dakota laws governing the adequacy of medical records and the provision of medical records to the patient and other medical providers treating the patient. Thus, any provider treating a patient via telemedicine must maintain adequate medical records for each encounter that are available to the patient and other providers.

e) Licensees must have the ability to make appropriate referrals of patients not amenable to diagnosis or complete treatment through a telemedicine encounter, including those patients in need of emergent care, or complementary in-person care.

General Authority: 28-32-02, NDCC

Statute Implemented: 43-17-31, NDCC

50-02-15-04. Prescribing. A licensee who has performed a telemedicine examination or evaluation meeting the requirements of this chapter may prescribe medications according to the licensee's professional discretion and judgment, with one exception: ~~Licensees may not prescribe opioids through a telemedicine encounter.~~ Opioids may only be prescribed through telemedicine if done so as a FDA approved medication assisted treatment (MAT) for opioid use disorder. Opioids may not be prescribed through a telemedicine encounter for any other purpose.

Licensees who prescribe controlled substances, as defined by North Dakota law, in circumstances allowed under this rule, must comply with all state and federal laws regarding the prescribing of controlled substances, and must participate in the North Dakota Prescription Drug Monitoring Program.

General Authority: 28-32-02, NDCC
Statute Implemented: 19-02.1-15.1, NDCC; 19-03.1-22.4, NDCC; 19-03.5-09(2), NDCC; 43-17 , NDCC

ATTACHMENT 2

TELADOC.

December 4, 2017

The Honorable Bill Devlin
Chairman, Administrative Rules Committee
North Dakota Legislative Assembly
P.O. Box 505
Finley, North Dakota 58230-0505

Dear Chairman Devlin and members of the North Dakota Administrative Rules Committee:

Teladoc appreciates this opportunity to provide its comments to the North Dakota Administrative Rules Committee on the proposed rules submitted by the North Dakota Board of Medicine ("Board") relating to Telemedicine Services. Teladoc respects the role of the Board in considering the appropriate rules and clinical practice guidelines that are designed to be protective of public health and maintain high-quality care for patients.

Teladoc has vast experience in telemedicine as it is the nation's first and largest telehealth platform, delivering on-demand healthcare anytime, anywhere, via mobile devices, a web-based portal, video and interactive audio. Teladoc provides services in all fifty states and has over 20.1 million enrollees, who benefit from access to Teladoc 24 hours a day, seven days a week, 365 days a year. After more than a decade of service and over 2.5 million telehealth visits, Teladoc has yet to be subject to a single malpractice claim.

Teladoc has expressed its concerns with the North Dakota Board of Medicine's proposed rules under NDAC 50-02-15 and specifically with NDAC 50-02-05-03(c) entitled Evaluations and examinations required to establish a patient-licensee relationship, as follows:

> "Prior to initially diagnosing or treating a patient for a specific illness or condition, an examination or evaluation must be performed. An examination or evaluation may be performed entirely through telemedicine, if the examination is equivalent to an in-person examination. A video examination that utilizes appropriate diagnostic testing and use of peripherals that would be deemed necessary in a like in-person examination or evaluation would meet this standard, as would an examination conducted with an appropriately licensed intervening health care provider, practicing within the scope of their profession, providing necessary physical findings to the licensee. An examination or evaluation that consists only of a static online questionnaire or an audio conversation will not be considered to meet the standard of care."

Teladoc's primary concern with the above excerpted passage is that limiting the establishment of the patient licensee relationship to a video examination it is too restrictive and lacks evidentiary support. The language is too restrictive in the respect that it fails to include the use of interactive audio as a means of initially establishing the patient-licensee relationship. The efficacy of Telehealth utilizing interactive audio has been shown through peer-reviewed literature and also

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seems to be conceived of by the North Dakota State Legislature in its recent passage of NDCC § 26.1-36-09.15(g), which defines telehealth as follows:

> g. "Telehealth":
>
> (1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.
>
> (2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.
>
> (3) Does not include the use of audio-only telephone, electronic mail, or facsimile transmissions.

NDCC § 26.1-36-09.15 includes within its definition "interactive audio" as a method of delivery of Telehealth services that all health insurance plans must cover in the State of North Dakota. The North Dakota Board of Medicine's decision to exclude interactive audio as a means of establishing a patient-licensee relationship has not been supported by any evidentiary finding, identified health care concern or any peer-reviewed literature that supports the necessity for video as a component in establishing the patient-licensee relationship in every telemedicine visit. Rather than providing any evidentiary basis for the necessity of a video component at the initial stage, the Board seems to have arbitrarily excluded interactive audio in the proposed rule.
Teladoc submits the following amendment to 50-02-05-03 for the Administrative Rules Committee's consideration that tracks with best practices on telemedicine policy throughout the country:

> c) Evaluations and examinations required to establish a patient-license relationship. Prior to initially diagnosing or treating a patient for a specific illness or condition, an examination or evaluation must be performed. An examination or evaluation may be performed entirely through telemedicine, if the examination or evaluation is equivalent to an in-person examination. A video examination that utilizes appropriate diagnostic testing and use of peripherals that would be deemed necessary in a like in-person examination or evaluation would meet this standard, the use of interactive audio with asynchronous store and forward technology or audio-video, at the professional discretion of the physician, would meet this standard as would an examination conducted with an appropriately licensed intervening health care provider, practicing with the scope of their profession, providing necessary physical findings to the licensee. An examination or evaluation that consists only of a static online questionnaire or an audio conversation "in isolation" will not be considered to meet the standard of care.

It seems almost an absurdity to assume that a North Dakota licensed physician would perform a Telemedicine visit or provide an examination or evaluation by Telemedicine without having the appropriate information available to the licensee, as the circumstances dictate. In this way,

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Teladoc suggests that the restrictive language in the proposed rule usurps the licensee's discretion and replaces it with an arbitrary rule that excludes another method of delivery of telemedicine services.

It is also important to recognize that North Dakota is a largely rural state and individuals that reside in areas with limited access to broadband or high-speed telecommunications services may not be able to obtain telemedicine services due to their inability to utilize a video platform. Furthermore, certain individuals that are seeking care by telemedicine may also prefer a telehealth visit established by interactive audio, for example, over video. There has been significant use of telemedicine in the field of telemental health, telepsychiatry or telebehavioral health ("telemental health"). Telemental health services are utilized effectively in the treatment of various types of mental health disorders including anxiety, agoraphobia, substance abuse, and PTSD. Many patients may have issues with receiving treatment for such disorders due to perceived stigmas and may be more inclined to seek to treatment through telemedicine. Some telemental health patients may even prefer to initiate a telemedicine visit by interactive audio rather than through video. Consequently, the Board's restrictive rules for establishing the patient-licensee relationship, potentially excluding interactive audio, may leave many North Dakotans without access to care that is not available to them due to the unavailability of broadband internet services or care with which they are comfortable.

Telemedicine is a potential solution to issues related to healthcare access in communities that lack sufficient facilities and/or practitioners to address their needs locally. A small town in North Dakota may not have a hospital or physician available to address an identified health care need. Having widely accepted technologies, such as interactive audio, available to a licensee in providing telemedicine to North Dakota patients seems to be a reasonable goal for North Dakota and this Administrative Rules Committee. Utilizing technology specific language will almost certainly limit the availability and access to telemedicine of North Dakotans, which will disproportionately fall on those in rural communities where Telemedicine would have its most beneficial application.

Any alleged concerns that licensees would practice telemedicine in a substandard manner should be offset by the Board's authority to review a licensee practicing telemedicine in North Dakota and discipline such an individual for a violation of the appropriate standard of care. Just as the board disciplines licensees practicing traditional, in-person medicine. In fact, many states policy on telehealth is nothing more than a statement that Licensees are held to the same standard of care and [the] same ethical standards..." while practicing Telemedicine as those practicing "traditional, in-person medicine" and nothing more.

Teladoc encourages the use of technology neutral language that will allow for future development and innovation in the field of telemedicine. Teladoc also points to a potential conflict with the legislative intent of NDCC 26.1-36-09.15 in providing for telehealth services, including interactive audio, where the proposed administrative rule restricts the provision of telehealth services by interactive audio. Pursuant to NDCC 28-32-18, there has been no showing by the Board of Medicine that it has fully considered the multiple comments that it received

1945 Lakepointe Dr, Lewisville, TX 75057
P (214) 302-5200 | F (972) 661-2312 | Teladoc.com

TELADOC.

requesting that the Board include interactive audio as a means of establishing the patient-licensee relationship. Finally, there does not appear in the record any substantive discussion as to the board's analysis in restricting the establishment of the patient-licensee relationship to a video examination. The Board's restricting the establishment of the patient-licensee relationship to a video examination is arbitrary and, accordingly, this Administrative Rules Committee should either amend NDAC 50-02-05-03(c), as suggested herein or strike the language in the first paragraph of NDAC 50-02-05-03(c) appearing after the sentence "An examination or evaluation may be performed entirely through telemedicine, if the examination or evaluation is equivalent to an in-person examination."

Teladoc appreciates the opportunity to comment on the proposed regulations. If you need more information or have any questions, please do not hesitate to contact me at (434) 841-3716.

Best Regards,

Claudia Tucker
Vice President Government Affairs
Teladoc

cc: Senator Nicole Poolman, Vice Chair
Representative Randy Boehning
Representative Joshua A. Boschee
Representative Kim Koppelman
Representative Scott Louser
Representative Brandy Pyle
Representative Mary Schneider
Representative Jay Seibel
Representative Nathan Toman
Representative Robin Weisz
Senator Howard Anderson, Jr.
Senator Kelly Armstrong
Senator Ralph Kilzer
Senator Jerry Klein
Senator Scott Meyer
Senator David Rust

1945 Lakepointe Dr, Lewisville, TX 75057
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APPENDIX J

Allergy & Asthma NETWORK

8229 Boone Boulevard, Suite 260, Vienna VA 22182 · 800.878.4403 · *AllergyAsthmaNetwork.org*

November 29, 2017

Administrative Rules Committee
c/o Vonette Joy Richter, Code Reviser
Legislative Council
600 East Boulevard Avenue
Bismarck, North Dakota 58505-0360

Dear Chairman Devlin and members of the Administrative Rules Committee:

On behalf of Allergy & Asthma Network, I respectfully request draft regulation 50-02-15 be reconsidered due to concerns about the regulation's potential negative impact on patients and health care in North Dakota. We previously submitted comment to the Board of Medicine requesting an amendment of the draft regulation to eliminate restrictive language and expand care options while preserving patient safety.

High-quality telemedicine is an important part of a modern and efficient healthcare system, and Allergy & Asthma Network is committed to working with policymakers to develop legislation and regulations that appropriately balance patient safety and access to treatment.

If you have any questions or need more information, please contact me or our Director of Advocacy, Charmayne Anderson at 703-641-9595. We appreciate your service and consideration.

Sincerely,

Tonya A. Winders

Tonya A. Winders
President and CEO

Attachment: Letter to North Dakota Board of Medicine

SB 2094 1/9/19 #2 Pg 1-9

Allergy & Asthma NETWORK

8229 Boone Boulevard, Suite 260, Vienna VA 22182 · 800.878.4403 · *AllergyAsthmaNetwork.org*

October 9, 2017

North Dakota Board of Medicine
418 E. Broadway Avenue, Suite 12
Bismarck, North Dakota 58501

Re: Proposed rules pertaining to telemedicine

Dear Members of the North Dakota Board of Medicine:

Allergy & Asthma Network supports telemedicine legislation and regulations that maximize allowable technologies and enable patients to have greater access to high-quality care. As the leading national nonprofit dedicated to protecting and improving the health of people with asthma, allergies and related conditions, we believe progressive policies regarding telemedicine are essential to fulfilling that goal.

In its current form, proposed regulation 50-02-15 inhibits North Dakotans ability to utilize telemedicine services for affordable, convenient care by including a medically-unnecessary provision requiring the use of audio-visual technology to establish a patient-license relationship. A high-speed Internet connection is needed to support streaming video, and many North Dakotans lack access to such broadband Internet service.

Physicians who deliver care through telemedicine should be held to the same standards as they would be if they were treating a patient in an office. Many patients who suffer from allergies, especially those with allergy-related skin conditions, would benefit from greater and more convenient access to a physician. For patients with chronic respiratory conditions like asthma and COPD, telemedicine would be an effective way to provide disease education and improved disease management. This is particularly true in North Dakota's many rural areas, where visiting a physician's office could require traveling lengthy distances through adverse weather conditions.

We believe telemedicine functions as a complement to existing healthcare resources by increasing access to affordable medical treatment. Allergic reactions and related conditions can occur at any time, and patients should have the option to pursue treatment through telemedicine rather than traveling to a hospital's emergency room in the middle of the night.

We respectfully request that the Board remove the audio-visual mandate from the proposed regulation. Thank you for your attention to this matter.

Sincerely,

Tonya A. Winders

Tonya Winders
President and CEO

SB 2041 1/9/19 #2 Pg 50

APPENDIX K

The ERISA Industry Committee

Driven By and For Large Employers

1400 L Street, NW, Suite 350, Washington, DC 20005 • (202) 789-1400 • www.eric.org

Adam Greathouse, Health Policy Associate

December 4, 2017

Administrative Rules Committee
North Dakota Legislative Council
600 E. Boulevard Ave.
Bismarck, ND 58505-0360

RE: Comment on Proposed Telemedicine Rules for December 5, 2017 Administrative Rules Committee Meeting

Delivered via email to yrichter@nd.gov

Dear Chairman Devlin and Members of the Administrative Rules Committee:

On behalf of The ERISA Industry Committee (ERIC), thank you for accepting input from interested stakeholders as you consider the North Dakota Board of Medicine's proposed rules regarding telemedicine. ERIC is the only national association that advocates exclusively for large employers on health, retirement, and compensation public policies at the federal, state, and local levels. We speak in one voice for our members on their benefit and compensation interests, including many members with employees and retirees in North Dakota.

As plan sponsors, our members strive to provide the best health care possible to their employees, retirees, and families at an affordable cost. At ERIC, we seek to enhance our members' ability to provide high-quality, affordable health care, and we recognize the significant opportunity provided by telemedicine to modernize health care delivery and improve access to quality medical care for workers and their dependents. Telemedicine minimizes the time spent attending a health care provider visit, making telehealth a great value to working parents, caregivers, and others struggling to balance work and family demands. It also provides access to care for rural and urban underserved populations, retirees, the elderly, disabled employees, and those with language barriers, chronic conditions, or transportation barriers that may otherwise not have access to care.

We applaud the Board of Medicine's proposed rules providing for the same standard of care for telemedicine visits as for those conducted in-person and for permitting the patient-licensee relationship to be established via telemedicine. The benefits of telemedicine will be greatly diminished if it can only be used by those with preexisting patient-licensee relationships. For example, many people that have recently moved for work, college students, those in need of a specialist, or those that have never been to a health care provider would not be able to utilize telemedicine services if a preexisting relationship was required.

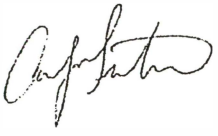
In Proposed Rule 50-02-05-03, however, to establish a patient-licensee relationship via telemedicine, the mode of delivery must be by video examination, even though the Board's proposed telemedicine definition includes "asynchronous store-and-forward technologies." We encourage you to send these rules back to the Board to reconsider the restrictive video requirement to establish the patient-licensee relationship. The State Legislature defined telehealth in 2015 as "the use of interactive audio, video, or other communications technology that is used

by a health care provider or health care facility at a distant site to deliver health services at an originating site...." At ERIC, we support technology-neutral requirements in telemedicine regulations because restrictive requirements create a barrier to access—especially in rural areas where a significant proportion of the population lacks access to a fast, reliable internet connection capable of two-way audio-video communication.

We believe that it should be within the health care provider's professional judgment to determine if a telemedicine visit will meet the requisite standard of care and what type of technology is appropriate to establish a relationship with a certain patient. Additionally, restrictive technology requirements prevent new forms of telemedicine technology, which are ever-evolving, from being quickly implemented. Patients should not be prevented from using telemedicine solely because they lack the capability to communicate with a provider via video. We request that the Board of Medicine consider allowing interactive audio in conjunction with asynchronous store-and-forward technology to be used to establish the patient-licensee relationship.

Thank you for accepting our input on this rule. ERIC is pleased to represent large employers with the goal of ensuring telemedicine benefits are accessible for millions of workers, retirees, and their families. If you have any questions concerning our written testimony, or if we can be of further assistance, please contact Adam Greathouse at agreathouse@eric.org or 202-627-1914.

Sincerely,



Adam J. Greathouse
Health Policy Associate

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APPENDIX L

AARP Real Possibilities in
North Dakota

107 W. Main Avenue, #125 ¦ Bismarck, ND 58501
1-866-554-5383 ¦ Fax: 701-255-2242 ¦ TTY: 1-877-434-7598
aarp.org/nd ¦ aarpnd@aarp.org ¦ twitter: @AARP_ND
facebook.com/AARPND

December 1, 2017

VIA EMAIL

North Dakota Administrative Rules Committee
600 East Boulevard Avenue
Bismarck, ND 58505-0360

Dear Chairman Devlin and Members of the Committee:

We appreciate the efforts of both the Committee and the North Dakota Board of Medicine to safely regulate telemedicine in the state. On behalf of AARP North Dakota and our approximately 86,000 members in the state, AARP respectfully requests the Committee reject the proposed telemedicine regulations before you in order that Chapter 50-02-15 may be amended to remove restrictive technology requirements in Rule 50-02-05-03.

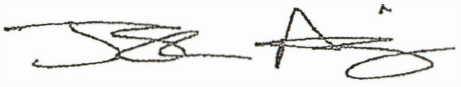
The increased attention directed toward telemedicine is understandable. As a new, promising tool for delivering care, it holds tremendous potential to eliminate barriers that hinder efforts to provide treatment and care. This is true not only for residents in rural and medically underserved areas but for patients across the state who have issues with mobility and travel. AARP believes that telemedicine offers an option for coordinating and obtaining high-quality care that is practical, affordable and effective, as not every medical condition warrants an arduous trip to an office, urgent care clinic or hospital emergency room.

Expanding the use of telemedicine can help individuals and family caregivers access health care and long-term services and supports in new ways, allowing individuals to live independently in their homes and communities and making it easier for family caregivers, many of whom work full time, to care for their loved ones. When one takes into account that in North Dakota there are approximately 62,100 family caregivers providing $860 million in unpaid care for their loved ones, telemedicine can play a meaningful role in helping not only patients, but also family caregivers who oftentimes are providing the bulk of that patient's care.

This proposal, as currently drafted, has potential to impede access to healthcare via telemedicine for patients, as well as their family caregivers, across North Dakota due to the requirement that the patient-provider relationship be established via video examination. Such a move would inappropriately reduce patient access to care and would represent North Dakota swimming against the national current of states expanding, not restricting, access to telemedicine.

Please let us know if you need us to submit additional correspondence or provide testimony on this matter, or other ways we can demonstrate our view on this important issue.

Kind regards,



Josh Askvig
State Director
AARP North Dakota

cc: Executive Secretary Bonnie Storbakken, North Dakota Board of Medicine

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APPENDIX M

United Spinal Association
www.unitedspinal.org

December 4, 2017

Administrative Rules Committee c/o
Vonette Joy Richter, Attorney at Law
Legislative Council
600 E. Boulevard Ave.
Bismarck, ND 58505-0360

Dear Chairman Devlin and members of the Administrative Rules Committee:

Please see the enclosed letter from the United Spinal Association to the Board of Medicine in which we requested an amendment to draft regulation 50-02-15 as it pertains to the use of telemedicine in North Dakota. This request was not considered favorably, and United Spinal Association remains concerned about the restrictive nature of these regulations and their impact on patients across North Dakota, in particular those with spinal cord injuries and disorders. North Dakota is a heavily rural state with many residents who lack access to broadband, and the practical effect of the Board's proposed regulations would be to eliminate the use of telemedicine for a vast majority of the state's residents.

We ask that you consider the importance of telemedicine and its ability to improve access to healthcare for individuals with spinal cord injuries and other types of physical disabilities, and all North Dakota patients, as you assess these proposed regulations.

While it is important that telemedicine providers be regulated to protect the public, it is equally important that policies not be designed to impede access. With the requested amendments, the state's telemedicine regulations would ensure that North Dakotans have greater access to medical care from providers who comply with federal and state requirements. If you have any questions, please do not hesitate to contact Jasey Cárdenas, Senior Policy Associate, at jcardenas@unitedspinal.org or (202) 556-2076, x7104.

Sincerely,

Alexandra Bennewith

Alexandra Bennewith, MPA
Vice President, Government Relations

United Spinal Association
www.unitedspinal.org

October 13, 2017

North Dakota Board of Medicine
418 E Broadway Ave, Suite 12
Bismarck, ND 58501

Re: Chapter 50-02-15 and the use of telemedicine

Dear Members of the Board:

United Spinal Association writes to submit public comments requesting that that the language in draft regulation Chapter 50-02-15 be amended. We understand the formal comment period has just passed, but we hope that our organization's views will be considered at the board meeting next week as you take up the issue of telemedicine. Specifically, amending the restrictive language carving out allowable technology in telemedicine will allow the state of North Dakota to maximize expanded access to healthcare for people with disabilities through telemedicine. United Spinal Association supports public policies to promote and improve the quality of life for individuals with spinal cord injuries and diseases.

United Spinal Association is the largest disability-led national non-profit organization founded by paralyzed veterans in 1946 and has since provided service programs and advocacy to improve the quality of life of those across the life span living with spinal cord injuries and disorders (SCI/D) such as multiple sclerosis, amyotrophic lateral sclerosis (ALS), post-polio syndrome and spina bifida. United Spinal represents over one million individuals with spinal cord injuries and disorders, over 50 chapters, over 100 rehabilitation hospital members and close to 200 support groups nationwide. Throughout its history, United Spinal Association has devoted its energies, talents and programs to improving the quality of life for these Americans and for advancing their independence. United Spinal Association is also a VA-recognized veterans service organization (VSO) serving veterans with disabilities of all kinds.

United Spinal Association respectfully requests the Committee amend draft Chapter 50-02-15 to insert language in Section 3. Subsection (c) to explicitly allow the use of video in establishing the physician-patient relationship. The current requirement for audio-visual connections in establishing this relationship creates a barrier to access and removes another avenue for individuals with disabilities to obtain quality intervention via telemedicine.

Telemedicine is a valuable tool for meeting the needs of North Dakotans, particularly those with disabilities, and United Spinal Association strongly supports technology-neutral telemedicine regulations for the purpose of improving public access to high-quality health care. For people in rural areas and those living with spinal cord injuries or other physical disabilities, obtaining in-person care can be a difficult process.

While it is important that telemedicine providers be regulated to protect the public, it is equally important that policies not be designed to impede access. With the requested amendments, the state's telemedicine regulations would ensure that North Dakotans have greater access to medical care from providers that comply with federal and state requirements. If you have any questions, please do not hesitate to contact Jasey Cárdenas, Senior Policy Associate, at jcardenas@unitedspinal.org or (202) 556-2076, x7104.

Sincerely,
Alexandra Bennewith
Alexandra Bennewith, MPA
Vice President, Government Relations

SB 2094 1/9/19 #2 pg 52

Bonnie Storbakken

From: Etherington, Rosalie R. <retherington@nd.gov>
Sent: Monday, December 4, 2017 7:09 PM
To: Bonnie Storbakken
Subject: Regulatory Rules Committee NDBOM

Ms. Storbakken and members of the Regulatory Rules Committee

I write to you with concern regarding the decision to not allow telemedicine prescribing for suboxone or buprenorphine. These medications are effective in medication assisted treatment of opioid use disorders. The fact that the board has chosen to be even more restrictive than the current federal rules that allow telemedicine prescribing after an in-person examination is eliminating this choice of treatment for rural North Dakotans.

There are only 65 practicing psychiatrists in North Dakota. This small number of physicians coupled with our frontier and rural counties, plus the distance necessary for patients to travel, eliminates the possibility for use of these effective medications. The public behavioral health system serves more than 10,000 North Dakotan's per year, many of whom suffer from severe substance use disorders. To maximize access to needed care we rely on telemedicine for prescribing and counseling. The limiting of these medications for use in telemedicine will adversely affect our clients, some of the poorest and most vulnerable citizens of our state.

Thank you for your attention to this matter and consideration of bringing this forward to the board.

Rosalie Etherington, PhD
Chief Clinics Officer, DHS Human Service Centers
Superintendent, North Dakota State Hospital
retherington@nd.gov
701-253-3964

SB 2044 1/9/19 #2 pg 57

Bonnie Storbakken

From: -Info-Dept. of Health <health@nd.gov>
Sent: Thursday, December 14, 2017 1:53 PM
To: Bonnie Storbakken
Subject: FW: Incident# 1050239 - North Dakota State Portal Inquiry forwarded from the Service Desk

Follow Up Flag: Flag for follow up
Flag Status: Flagged

The ITD Service Desk forwarded this to the State Health Department.

Londa

From: ITD Service Desk
Sent: Thursday, December 14, 2017 12:48 PM
To: -Info-Dept. of Health <health@nd.gov>
Subject: Incident# 1050239 - North Dakota State Portal Inquiry forwarded from the Service Desk

Hello Health, Dept. of,

Please respond to the inquiry that was submitted from the 'Contact Us' form on the State Portal site. If your agency is unable to fulfill this inquiry please contact the Service Desk.

Name: Chase Larson
Email: clarson@evisit.com

Description:
Contact Us inquiry

To whom it may concern,

My name is Chase Larson and as Director of Marketing, I speak on behalf of the national telemedicine company eVisit.

We would like to formally stand with the North Dakota Board of Medicine and their proposed rule that would require an in-person visit for a patient's first telemedicine appointment.

As an entity offering telemedicine to hundreds of thousands of patients, we have seen great success when the initial doctor-patient relationship has had the adequate opportunity to foster trust, care and accuracy. Though this may require more time and effort upfront, we know this investment pays great dividends over the duration of the virtually administered healthcare. In the end, more adoption comes as a result and those in the more rural reaches of the state are afforded greater access.

The Board of Medicine has our full support in this endeavor. Please let eVisit know if we can offer anything additional in the effort to provide North Dakota residents the best healthcare experience possible.

Best regards,
Chase Larson
clarson@evisit.com

Bonnie Storbakken

From: Hirsch, Robin A. <rhirsch@nd.gov>
Sent: Wednesday, November 15, 2017 10:18 AM
To: Bonnie Storbakken
Cc: Ideker, Maureen; Shropshire, Kimberly
Subject: Maureen's info

Maureen's information

She was asking about the "branching algorithm" questionnaire vs a "state" questionnaire

Maureen Ideker RN, BSN, MBA
System Director of Telehealth
Essentia Health
Holy Trinity Hospital
115 West Second Street, Graceville, MN 56240
C: 218-371-0596
maureen.ideker@essentiahealth.org

Thanks!

Robin Hirsch

Human Resource Officer
Information Technology Dept.
4201 Normandy Street
Bismarck, ND 58503-1324
701.328.3175
rhirsch@nd.gov

SB 2094 1/9/19 #2 pg 59

Bonnie Storbakken

From: Tufte, Mylynn K. <mylynntufte@nd.gov>
Sent: Tuesday, December 19, 2017 11:17 AM
To: Tufte, Mylynn K.
Subject: HIPAA guidance related to opioid crisis - New Resource

Greetings,

This was recently shared from our Regional Federal partners. I believe this to be encouraging in light of our expansion of medication assisted treatment (MAT) and telemedicine options.

Happy Holidays,

Mylynn

***HHS highlights Office for Civil Rights' ongoing response to the opioid crisis, while implementing the 21st Century Cures Act

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) today launched an array of new tools and initiatives in response to the opioid crisis, while implementing the 21st Century Cures Act (Public Law 114-255). OCR continues its work to ensure that patients and their family members can get the information they need to prevent and address emergency situations, such as an opioid overdose or mental health crisis. At the same time, these tools and initiatives also fulfill requirements of the 21st Century Cures Act to ensure that the healthcare sector, researchers, patients, and their families understand how the Health Insurance Portability and Accountability Act (HIPAA) protects privacy and helps improve health and healthcare nationwide.

Highlights of these actions include:

- Two new HIPAA webpages focused on information related to mental and behavioral health, one for professionals and another for consumers. These webpages reorganize existing guidance to make it more user-friendly and provide a one-stop resource for our new guidance and materials. This guidance is an important step forward in clarifying the circumstances under which HIPAA permits a covered entity to disclose information to family members and caregivers.
    - For consumers: https://www.hhs.gov/hipaa/for-individuals/mental-health/index.html
    - For professionals: https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html
- These webpages contain new HIPAA guidance on sharing information related to mental health and substance use disorder treatment with a patient's family, friends and others involved in the patient's care or payment for care. The new information includes: a package of fact sheets; an infographic; decision charts, including materials specifically tailored to the parents of children who have a mental health condition; and scenarios that address sharing information when an individual experiences an opioid overdose.
- New collaboration with partner agencies within HHS to identify and develop model programs and materials for training healthcare providers, patients, and their families regarding permitted uses and disclosures of the protected health information of patients seeking or undergoing mental health or

substance use disorder treatment, and to develop a plan to share the programs and materials with professionals and consumers.

- Updated guidance on HIPAA and research, as called for in the Cures Act: https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html
- Launch of a working group to study and report on the uses and disclosures under HIPAA of protected health information for research purposes. The working group will include representatives from relevant federal agencies as well as researchers, patients, healthcare providers, and experts in healthcare privacy, security, and technology. The working group will release a report addressing whether uses and disclosures of PHI for research purposes should be modified to facilitate research while protecting individuals' privacy rights.

For additional information on HIPAA, visit: https://www.hhs.gov/hipaa/

Mylynn Tufte, MBA, MSIM, BSN
State Health Officer
North Dakota Department of Health
600 E. Boulevard Ave. Dept. 301
Bismarck, ND 58505
W: 701-328-2372

NORTH DAKOTA
DEPARTMENT *of* HEALTH

NGA

MEMORANDUM

TO: North Dakota Rural Health Learning Collaborative State Team
FROM: Sonia Pandit, Senior Policy Analyst
SUBJECT: Teleprescribing for Controlled Substances, Including Drugs for Opioid Addiction Treatment
DATE: December 1, 2017
CC: Lauren Block, Program Director; Sandra Wilkniss, Program Director

This memo responds to a request from the North Dakota state team regarding examples of states that allow providers to prescribe controlled substances, including drugs used for medication-assisted treatment (MAT) such as buprenorphine, via telemedicine.

State Law Landscape

The ability of providers to prescribe controlled substances via telemedicine varies among states. While some states explicitly prohibit the prescribing of controlled substances via telemedicine, there are other states that allow it, are silent, or provide specific conditions for allowance or prohibition (*e.g.*, cannot be used in connection with treatment of chronic nonmalignant pain). Furthermore, some state laws describe specific teleprescribing standards whereas others defer to the state Boards of Medicine.

Delaware

This year, Delaware implemented a regulation allowing opioid prescribing via telemedicine for addiction treatment programs offering MAT that have received a Division of Substance Abuse and Mental Health waiver to use telemedicine through the Division's licensure or renewal process. Attached is a copy of the proposed regulation. Relevant language regarding telemedicine is on page 23 and below:

> "No opioid prescribing is permitted via telemedicine with the exception of addiction treatment programs offering medication assisted treatment that have received a Division of Substance Abuse and Mental Health (DSAMH) waiver to use telemedicine through DSAMH's licensure or renewal process as outlined in 16 DE Admin. Code 6001 Substance Abuse Facility Licensing Standards Sec. 4.15. All other controlled substance prescribing utilizing telemedicine is held to the same standards of care and requisite practice as prescribing for in-person visits."

Ohio

This year, the Ohio Medical Board adopted new rules for telemedicine prescribing of drugs and controlled substances, allowing providers to prescribe drugs via telemedicine without conducting an in-person examination. Effective March 23, 2017, the new rule 4731-11-09 and rule 7331-11-01 set forth the requirements a physician must follow when prescribing opioids via telemedicine in Ohio:

An Ohio physician may prescribe controlled substances via telemedicine, without an in-person exam, if the physician satisfies the nine steps outlined for prescribing non-controlled substances ***and*** when one of the following six situations exists:

- The patient is an "active patient" of a health care provider who is a colleague of the physician and the controlled substances are provided through an on call or cross coverage arrangement between the

health care providers. "Active patient" is a defined term under the new rules and means that "within the previous twenty-four months the physician or other health care provider acting within the scope of their professional license conducted at least one in-person medical evaluation of the patient or an evaluation of the patient through the practice of telemedicine as that term is defined in 21 C.F.R. 1300.04, in effect as of the effective date of this rule."

- The patient is located in a DEA-registered hospital or clinic;
- The patient is being treated by, and in the physical presence of, an Ohio-licensed physician or health care practitioner registered with the DEA;
- The telemedicine consult is conducted by a practitioner who has obtained a DEA special registration for telemedicine;
- A hospice program physician prescribes the controlled substance to a hospice program patient in accordance with the board of pharmacy rules; or
- The physician is the medical director of, or attending physician at, an "institutional facility" (defined in rule 4729-17-01) and 1) the controlled substance is being provided to a person who has been admitted as an inpatient to or is a resident of an institutional facility, and 2) the prescription is transmitted to the pharmacy by a means that is compliant with Ohio board of pharmacy rules.

Virginia

In 2015, Virginia enacted a law updating provisions pertaining to use of telemedicine. Additionally, the Virginia Board of Medicine published Telemedicine Guidelines to instruct practitioners on the use of telemedicine. The guidelines address establishing a valid practitioner-patient relationship, licensure, evaluation and treatment, informed consent, medical records, privacy and security of patient information, and remote prescribing. Guidelines for remote prescribing and controlled substances are noted below:

- **Remote Prescribing & Controlled Substances.** Virginia physicians may prescribe medications via telemedicine (i.e., remote prescribing). Doing so is at the discretion of the physician, provided the prescribing is consistent with standards of care and lists the direct contact information of the prescriber (or prescriber's agent) on the prescription itself. Regarding controlled substances, prescriptions must comply with requirements set forth in Va. Code §§ 54.1-3408.01 and 54.1-3303(A). Physicians may prescribe Schedule VI medication via telemedicine when a doctor-patient relationship is established using face-to-face, two-way real-time communications services or store-and-forward technologies when all of the following conditions are met:
  - The patient has provided a medical history that is available for review by the prescriber;
  - The prescriber obtains an updated medical history at the time of prescribing;
  - The prescriber makes a diagnosis at the time of prescribing;
  - The prescriber conforms to the standard of care expected of in-person traditional exams including the use of diagnostic testing or physical examination, via condition-appropriate peripheral devices;
  - The prescriber is licensed in Virginia and authorized to prescribe;
  - If the patient is enrolled in a health plan, the prescriber is credentialed by the health plan as a participating provider and the prescribing meets the plan's qualifications for reimbursement; and
  - Upon request, the prescriber provides medical records from the consultation to patients or their primary care physicians in a timely manner.

West Virginia

In March 2016, West Virginia Gov. Earl Ray Tomblin signed into law, (HB 4463) implementing a variety of telemedicine practice standards and remote prescribing rules in the state. Remote prescribing without a prior in-person exam is permitted, including prescriptions for controlled substances, subject to certain limitations.

- A physician who practices medicine to a patient solely through the utilization of telemedicine technologies may not prescribe to that patient any Schedule II controlled substances.
- A physician may not prescribe any pain-relieving controlled substance listed in Schedules II through V as part of a course of treatment for chronic non-malignant pain solely based upon a telemedicine encounter.

The statute may require the WV Board of Medicine to rewrite some regulations to comply with state law and/or add a level of specificity. However, the Board had released a prior statement in which they defer to a physician's judgement as to whether or not to prescribe via telemedicine. The language is copied below:

> "Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters."

Oklahoma

Oklahoma Governor Mary Fallin signed into law SB 726, establishing new telemedicine practice standards, including explicitly allowing doctors to create valid physician-patient relationships via telemedicine without an in-person exam.

- **Telemedicine Prescribing**. A physician-patient relationship cannot be established via telemedicine or store and forward technologies for the purpose of prescribing opiates, synthetic opiates, semisynthetic opiates, benzodiazepine or carisprodol, but may be used to prescribe opioid antagonists or partial agonists.

Oklahoma already has medical board regulations (Okla. Admin. Code r. 435:10-7-13) and a position statement on the practice of telemedicine, and the new law may potentially require the Oklahoma Board of Medicine to rewrite some of its existing guidance to the extent it conflicts with the controlling provisions of the new statute.

Indiana

Former Indiana Gov. Mike Pence signed into law, on March 21, 2016, a HB 1263 regarding telemedicine practice standards and remote prescribing. Under the law, an Indiana provider may prescribe controlled substances via telemedicine, without an in-person exam, if the provider satisfies the conditions outlined for non-controlled substances *and* the following conditions are met:

- The prescription is not for an opioid, unless the opioid is a partial agonist that is used to treat or manage opioid dependence.
- The prescriber maintains a valid controlled substance registration.

- The prescriber meets the conditions set forth in the federal Ryan Haight Act.
- The patient has been examined in-person by a licensed Indiana health care provider and the licensed health care provider has established a treatment plan to assist the prescriber in the diagnosis of the patient.
- The prescriber has reviewed and approved that treatment plan and is prescribing for the patient pursuant to that treatment plan.
- The prescriber complies with Indiana's INSPECT prescription drug monitoring program.
- The prescription for a controlled substance is prescribed and dispensed in accordance with Indiana Code 35-48-7.

Michigan

Michigan Governor Rick Snyder signed into law SB 213, clarifying that health professionals in Michigan may prescribe controlled substances via telemedicine without an in-person examination if the following conditions are met:

- The health professional is a prescriber acting within the scope of his or her practice in prescribing the drug; and
- If the health professional is prescribing a controlled substance, he or she meets the requirements applicable to that health professional for prescribing a controlled substance.

The law also requires the prescriber to comply with both of the following provisions:

- If the health professional considers it medically necessary, he or she must provide the patient with a referral for other health care services geographically accessible to the patient, including emergency services; and
- After providing a telehealth service, the health professional, or a health professional acting under the delegation of another health professional, must make himself or herself available to provide follow-up health care services to the patient or refer the patient to another health professional for follow-up health care services.

SB 2094 1/9/19 #2 pg65

Bonnie Storbakken

From:	Jack McDonald <jackmcdonald@wheelerwolf.com>
Sent:	Wednesday, February 7, 2018 5:05 PM
To:	Bonnie Storbakken
Cc:	Jack McDonald
Subject:	Administrative Rules
Attachments:	AHIPs Comments on Proposed Chapter 50-02-15 - Telemedicine Final.docx

Bonnie: Attached – and hopefully sent now to the correct address - are some comments from America's Health Insurance Plans (AHIP) concerning the ND Board of Medicine's proposed telemedicine administrative rules, and particularly proposed Section 50-02-05-01 concerning the provider-patient relationship. Would you please bring these comments to the attention of your committee that will be considering the proposed rules Feb. 9. Let me know if you have any questions. Thank you for your consideration.

Jack McDonald
WHEELER WOLF LAW FIRM
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Bismarck, ND 58502-1776
Ph: 701-751-1776; Fx: 701-751-1777
jackmcdonald@wheelerwolf.com

SB 2094 1/9/19 #2 pg 4

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Insurance Plans

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South Building
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202.778.3200
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February 7, 2018

Bonnie Storbakken
Executive Secretary
ND Board of Medicine
418 E. Broadway, Ste. 12
Bismarck, ND 58501

Re: AHIP's Comments on Proposed Section 50-02-05-01 - Telemedicine

Dear Executive Secretary Storbakken:

I am writing on behalf of America's Health Insurance Plans (AHIP) to raise concerns we have about the North Dakota Board of Medicine's proposed new Section 50-02-05-01 of the North Dakota Administrative Code regarding telemedicine definitions. AHIP is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. Our members are committed to providing consumers with affordable products that offer a broad range of robust provider networks of quality, cost-efficient providers.

As an industry, we are supportive of efforts to improve access to quality care. As technology has evolved in recent years, telemedicine has become an option for achieving this goal by removing traditional barriers to health care delivery such as distance, mobility, and time constraints.

As North Dakota works to create a regulatory scheme that will govern this model of health care delivery, we would like to raise a concern that we have regarding the current draft of proposed Section 50-02-05-01, which requires that valid provider-patient relationship be established through an initial in-person or audio-video evaluation. This requirement presumes that every service provided via electronic means, e.g., telemedicine, would have the provider evaluating the person through an audio or video means before performing the service. This requirement would also place a significant delay and operational constraint on a significant number of medical services.

For example, many pathology and radiology examinations are done through telemetry, without the providers establishing a provider-patient relationship, or meeting the person. We believe that

patients, providers, and health plans should have choice and flexibility regarding the use of telemedicine services. Mandating that a valid provider-patient relationship can only be established through an initial in-person or audio-video evaluation is an overly prescriptive standard that becomes an artificial barrier to care.

This standard also fails to consider the evolving nature of telemedicine technology, and it limits a patient's options when deciding on the best course of action to obtain health care. There are circumstances where telemedicine services provided via audio-only consultations are appropriate. The American College of Physicians has also noted that providers providing health care services via telemedicine can also establish a valid provider-patient relationship by consulting with another physician who does have a relationship with the patient or oversees his or her care.[1] Patients, their providers, and health plans are best positioned to make these types of determinations and need to have the flexibility to do so.

We appreciate the Board's efforts to develop regulations governing telemedicine that strike the right balance between patient safety and access. Thank you for the opportunity to provide feedback regarding proposed Section 50-02-05-01. If you have any questions, please do not hesitate to contact me at sorrange@ahip.org or (703-887-5285).

Sincerely,

Sara Orrange
Regional Director, State Affairs
America's Health Insurance Plans

[1] Doherty, Robert B., "Must telemedicine disrupt the patient-doctor relationship?" ACP Internist, January 2016. Accessed at https://acpinternist.org/archives/2016/01/washington.htm.

Definition of Telemedicine: Some direct to consumer (DTC) models utilize what they refer to as *"enhanced audio with asynchronous store-and-forward".* Essentially what this means is the patient fills out an online medical information questionnaire, and that information is forwarded electronically to the DTC practitioner. Thus, the term.

Language in the definition of telemedicine might include: "asynchronous store-and-forward does not include patient-supplied medical information."

"Patient-Licensee Relationship": a) under 3) would be written to suggest that the in-person equivalency only applies to 3). Because In-person equivalency should apply also to 2), the paragraph identification should be modified. Also, i) seems that should be free standing and not under 3).

"Standard of Care and Professional Ethics": b) *"A licensee practicing telemedicine shall verify the identity of the patient seeking care; and disclose the identity and licensure status of any licensee providing medical services to the patient. The patient must have the ability to verify the identity and licensure status of any licensee providing telemedicine services to the patient."* While the intent of this language maybe directed at DTC programs for first time visits, it probably is worth considering how this would impact practitioners providing care through established, facility-based telemedicine programs in the state. For example, how would this apply to a hospital-based specialist examining a patient in a clinic or critical access hospital in the state?

c) "... or by a provider designated by the licensee to act temporarily in the licensee's absence." This likely refers to "on-call" situations. This language makes clear the "licensee" who conducted the examination must designate the on call provider. Some DTC models provide that the patient self-select the DTC provider to provide care. So, when the patient self supplies the medical information on the company's website, they agree to terms and conditions, including a provision designating the company's DTC practitioners as their on call practitioner. If this loophole is to be closed, this language along with any other language or policy needs to specifically indicate that only the patient's practitioner may designate the on call arrangement.

Prescribing: This language may be stronger than Federal law, which may be the intention.

ATTACHMENT 3

MEDICAID MEDICAL POLICY
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 85 (6-9-2010)

Medicaid Policy Number (This number will be generated by Medical Services.)	Date Policy was Last Reviewed
NDMP-2012-0007	07-27-2017

Title
Telemedicine Services

Effective Date
8-1-2012

Revision Date(s)
7-2-2013; 01-14-2015; 05-31-2017; 07-27-2017

Replaces
Medicaid Coding Guideline; General Provider Manual information

Cross References

Description
Telemedicine is the use of interactive audio-video equipment to link practitioners and patients at different sites. Telemedicine involves two collaborating provider sites: an "originating site" and a "distant site". The client/patient is located at the originating site and the practitioner enrolled with ND Medicaid is located at the distant provider site to provide those professional services allowed/reimbursed by ND Medicaid.

Scope
Medical policies are systematically developed guidelines that serve as a resource for ND Medicaid staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the ND Medicaid program.

Policy
Telemedicine/Telehealth services via interactive audio-video equipment.

Policy Guidelines

1. To qualify as a professional service, actual visual contact (face-to-face) must be maintained between the practitioner and patient.
2. Services allowed/reimbursed by ND Medicaid include: New and established Office and Other Outpatient E/M services; Psychiatric diagnostic evaluation; Individual psychotherapy; Pharmacologic management; Speech Therapy, individual; Initial inpatient telehealth consultations.
3. Practitioners must append modifier GT to identify a service as being performed via telemedicine.
4. All services must be medically appropriate and necessary with supporting documentation of the service must be included in the patient's clinical medical record.
5. The originating and distant sites of telemedicine services cannot be in the same facility or community. The distant site must be a sufficient distance from the originating site to provide services to patients who do not have readily available access to such specialized services allowed/reimbursed by ND Medicaid via telemedicine.
6. A designated room at the originating site must have secure and appropriate equipment to ensure confidentiality, including camera(s), lighting, transmission and other needed electronics. Appropriate medical office amenities must be established in both the originating and distant sites. Skype or other unsecure web cam devices are not acceptable or allowed to be used for telehealth services.
7. Reimbursement will be made only to the distant practitioner during the telemedicine session. No reimbursement is allowed to a practitioner at the originating site if his/her sole purpose is the presentation of the patient to the practitioner at the distant site.

8. Reimbursement will be made to the originating site as a facility fee only in place of service office, inpatient hospital, outpatient hospital, or skilled nursing facility/nursing facility. There is no additional reimbursement for equipment, technicians or other technology or personnel utilized in the performance of the telemedicine service.

Benefit Application

- Coverage is limited to reimbursement for services identified by this policy via interactive audio-video telemedicine.
- Reimburs

ement is made for services provided by licensed professionals enrolled with ND Medicaid and within the scope of practice per their licensure only. • All service limits set by ND Medicaid for psychiatry, speech therapy,

and individual medical nutrition therapy apply to telemedicine services.

- Requires the presence of an individual to assist with establishing and maintaining the connection to the distant practitioner and have the ability to resond to the needs of the member.
- Out of State requests for telemedicine services require prior authorization. The services must be in compliance with the Out of State Program requirements.

Rationale Source

42 CFR 410.78 - Telehealth services - http://cfr.vlex.com/vid/410-78-telehealth-services-19805820;

CMS Issues Final Regulations on Telemedicine Credentialing Conditions of Participation - http://www.bricker.com/publications-and-resources/publications-and-resources-details.aspx?Publicationid=2165;

Telemedicine - Medicaid.gov - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

Code of Federal Regulations Citation(s)

42 CFR 410.78 - Telehealth services.

CODES	NUMBER	DESCRIPTION
CPT®	99201-99215	New and established Office and Other Outpatient E/M services
	90785	Interactive complexity (list separately in addition to the code for primary procedure)
	90791	Psychiatric Diagnostic Evaluation
	90792	Psychiatric Diagnostic Evaluation with medical services
	90832	Psychotherapy, 30 minutes with patient and/or family member
	90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
	90834	Psychotherapy, 45 minutes with patient and/or family member
	90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
	90837	Psychotherapy, 60 minutes with patient and/or family member
	90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
	92507	Speech Therapy, Individual
	99307-99310	Subsequent nursing facility care services

	G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
	G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
	G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
Applicable Modifier(s)	GT	Via interactive audio and video telecommunication systems
ICD-9 Procedures(s)	N/A	
ICD-9 Diagnosis(es)		Must support medical necessity and coded to the highest specificity.
Applicable Revenue Codes(s)	780	Telemedicine – Facility charges related to the use of telemedicine
HCPCS Code(s)	Q3014	Telehealth originating site facility fee
Type of Service	Medicine	As listed in the Medicine section of CPT®.
Place of Service	02	Telehealth - The location where health services and health related services are provided or received, through a telecommunication system *(effective 01/01/2017)*
	11	Office
	21	Inpatient Hospital
	22	Outpatient Hospital
	31	Skilled Nursing Facility
	32	Nursing Facility
	53	Community Mental Health Center

Telemedicine: Prescribing and the Internet

Christa Natoli
Director of the Center for Telehealth & e-Health Law and Program Director for the National Telehealth Resource Center

Natoli, Christa. "Telemedicine: Prescribing and the Internet." *Center for Telehealth & e-Health Law* (2011).

ABSTRACT

The author provides an overview of state laws as they relate to prescribing within the field of telemedicine. This report analyzes the various requirements necessitated by state medical boards before a physician is permitted to prescribe medication to a patient. The conclusions established within this paper have been verified by each state medical board.

Telehealth Overview

Advancements in medicine and technology have transformed the way health care is delivered to patients. However, laws governing these interactions have not evolved at the same pace, leaving many legal and regulatory questions unanswered in the area of Internet prescribing and telemedicine. To best analyze this issue, we must examine the laws that govern physicians prescriptive authority.

These laws are found at the state level because Article X of the Constitution grants medical boards the authority to regulate the health, safety, and welfare of their citizens. Although the federal government has the authority to establish specific, professional requirements for doctors under the purview of the Supremacy Clause, there is a strong legal presumption against federal preemption of state prescribing laws. As a result, prescribing regulations vary state-by-state.

However, even though these laws are governed at the state level and vary state-by-state, there are consistent legal issues within the law that determine a state's position on prescribing over the Internet. These two legal issues include the physical examination requirement and the pre-existing physician-patient relationship requirement.

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Pre-existing Physician-Patient Relationship

Many states require that a patient have a pre-existing relationship with their doctor before the physician is able to prescribe medication to a patient through telemedicine. In most states, if the patient does not have a pre-existing physician-patient relationship with the physician, the physician providing the telemedicine treatment is required to examine the patient in-person. For the most part, this law only applies to those states that do not allow for the examination to take place electronically.

Physical Examination

In order to prescribe medication to a patient, a physician is required to conduct a medical examination of that patient. This is a standard of care that is accepted by the medical community. Traditionally, before the onset of telemedicine, examinations took place in-person where the practitioner physically examined the patient face-to-face. As medicine and technology advanced, physicians were presented with new tools, such as telemedicine, that would allow a practitioner to conduct that examination electronically.

However, state laws governing these interactions were unclear as to whether a physician was legally permitted to examine the patient over the Internet, through telemedicine, and then prescribe medication to that patient.

The confusion is rooted in the fact that the laws governing these telemedicine interactions were written decades before telemedicine was even conceptualized. In efforts to bring clarity to this situation, a small group of state legislators and state medical boards began analyzing whether telemedicine examinations met the medical standard or care requirement. That is, will the examination result in a proper evaluation, diagnosis and treatment plan for that patient?

Still, to this day, very few states have specific language addressing the issue of telemedicine and Internet prescribing. For those states that do not have specific telemedicine and Internet prescribing laws, states refer physicians to their state's statute or board policies that generally speak to a physician's right to prescribe.

Presently, there are 41 states and 1 territory (Puerto Rico) that require a physician to conduct an in-person or face-to-face physical exam of the patient before the physician is

permitted to prescribe medication using telemedicine. This means patients living in remote and rural areas may be required to travel hundreds of miles to receive a physical exam in order to be eligible for treatment by telemedicine in the future. Many argue that this physical examination requirement defeats the purpose of telemedicine – a tool that is supposed to virtually bridge the gap between patient and provider.

Electronic Examination

However, there are a handful of states that specifically allow telehealth practitioners to conduct medical examinations using telemedicine technologies. These states require that the practitioner keep with the standard of care when conducting the electronic examination.

According to those state medical boards that allow for electronic examinations, practitioners should not prescribe medication to a patient unless they believe the electronic examination meets the standard of care within the medical community.

For example, if a physician believes that the patient's medical condition warrants an in-person examination, the practitioner is required to physically exam that patient before prescribing medication or administering treatment.

Medical Questionnaires

While some states allow for an electronic examination, almost all states do not allow for that examination to take place through the use of a medical questionnaire. State medical boards adhere to the belief that the administration of a on-line medical questionnaire as the sole basis for prescribing does not keep with the accepted standard of care.

In recent years, state medical boards have seen a rapid rise in illegitimate telemedicine operations by both new and established companies. Generally, these telemedicine business models do not offer a means to physically exam the patient. Rather the model solely relies on the patient to provide the physician with their own patient data and medical history, through the utilization of an on-line form. To date, there are 28 states that explicitly prohibit the use of an on-line medical questionnaire as the sole means for gathering patient data for means of prescribing medication.

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Establish Appropriate Follow-up Care

In addition to ensuring that a physician conducts a proper medical exam, 13 states require a physician to establish appropriate follow-up care with the patient after prescribing medication - four of those states allow for an examination to take place electronically.

Conclusion

Generally, states are conservative in what they view to be an appropriate physical examination requirement. However, many state legislators and medical boards assert that they are not trying to impede the advancement of telemedicine but rather ensure that patients receive access to quality health care services.

According to Dr. Jean Sumner, Georgia State Medical Board, "Access to no care at all is better than access to poor care. We are at the very start of telemedicine and we have the opportunity to shape this industry and make it great."

DISCLAIMER

This publication was made possible by grant number G22RH20216 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

Information contained in this report is current up to the date listed on the report. Note that the information is subject to change following action taken by a state's legislature, state agencies, state medical boards, or other applicable state government agency or body. CTeL will make every effort to provide the most current information.

The views and opinions expressed in the forgoing publication are solely those of the author and do not necessarily represent the views and opinion of the Center for Telehealth & e-Health Law, its Board of Directors, or its staff.

ACKNOWLEDGEMENTS:

Christa Natoli is the Director of the Center for Telehealth & e-Health Law and the Program Director for the National Telehealth Resource Center. Christa has an expertise in the areas of physician and nurse licensure, Internet prescribing, international telemedicine, and reimbursement. She also has extensive policy experience in the areas of health care law, nutrition and education, and international affairs.

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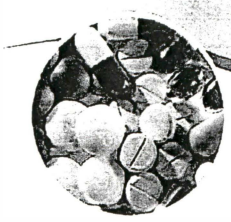

Public Health Law

Office for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention

Prescription Drug Physical Examination Requirements

The United States is in the midst of an unprecedented epidemic of prescription drug overdose deaths.[1] More than 41,000 people died of drug overdoses in 2011, and most of these deaths (22,810) were caused by overdoses involving prescription drugs.[2] Three-quarters of prescription drug overdose deaths in 2011 (16,917) involved a prescription opioid pain reliever (OPR), which is a drug derived from the opium poppy or synthetic versions of it such as oxycodone, hydrocodone, or methadone.[3] The prescription drug overdose epidemic has not affected all states equally, and overdose death rates vary widely across states.

States have the primary responsibility to regulate and enforce prescription drug practice. Although state laws are commonly used to prevent injuries, and their benefits have been demonstrated for a variety of injury types,[4] little information is available on the effectiveness of state statutes and regulations designed to prevent prescription drug abuse and diversion. This menu is a first step in assessing laws on physical exam requirements by creating an inventory of state legal strategies in this domain.

Introduction

This resource includes physical examination laws if they require a licensed practitioner to examine the patient before prescribing a medication. In this menu, "practitioner" refers to a physician, dentist, pharmacist, physician's assistant, nurse practitioner, or any other person licensed, registered, or permitted to prescribe, dispense, distribute, or administer a controlled substance. Laws are included

[1] For the purpose of this document, "overdose death" refers to death resulting from either intentional overdose or accidental overdose, which could be caused by a patient being given the wrong drug, taking the wrong drug in error, or taking too much of a drug inadvertently. CDC's National Center for Injury Prevention and Control also refers to overdose as a drug poisoning, which may or may not result in death.

[2] Centers for Disease Control and Prevention, Wide-ranging Online Data for Epidemiologic Research (WONDER) Database (2012) http://wonder.cdc.gov.

[3] *Id.*

[4] Schieber RA, Gilchrist J, & Sleet DA. *Legislative and Regulatory Strategies to Reduce Childhood Injuries*, 10 FUTURE CHILD. 1, 111–36 (2000).

only if they expressly require an examination or evaluation. Laws requiring a practitioner-patient relationship or use of a valid prescription are included only if the definition of practitioner-patient relationship or valid prescription expressly requires a physician examination.[5] Forty-one states[6] and the District of Columbia have one or more laws that require a prescriber or dispenser to ensure that prescriptions for medications are based on an examination of the patient.[7] States with these laws may require a physical examination as part of *prescribing* regulations, or may prohibit pharmacists and physicians from *dispensing* certain types of drugs if there is doubt the drugs were prescribed following a physical exam. Some states limit the applicability of the laws to certain drug types, apply laws only in certain circumstances, or contain exceptions to examination requirements.[8] Most states[9] and the District of Columbia have multiple physical examination laws and thus fall under multiple categories.

Type of Examination Required

Most examination laws[10] require a "physical examination" as the basis for prescribing and dispensing a controlled substance.

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[5] Some states, such as Missouri, have come to define the patient-practitioner relationship to include a physical examination through judicial interpretation. *See State v. Kane*, 586 S.W.2d 812 (App. E.D. 1979) (defining "patient-practitioner" as used in MO. ANN. STAT. § 195.204 to mean "first making some attempt to determine physical condition or health needs of person for whom he writes the prescription." *Id.* Those statutes are not included in this report.

[6] Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, and Washington.

[7] The nine states (Colorado, Illinois, Kansas, Michigan, New York, South Dakota, West Virginia, Wisconsin, and Wyoming) that do not have physical examination requirements according to this assessment likely have a physical examination requirement that may be incorporated into state law through a general provision requiring adherence to medical professional and ethical standards. The research on which this menu is based was limited to express provisions in statute or regulation.

[8] In this menu, the first effective dates of the specific provisions referenced are cited as "[legal citation] (eff. [year])." Where dates were either not provided within the laws or were unclear due to multiple revisions, this fact is cited as "[legal citation] (eff. date unclear, [estimated year])."

[9] Thirty-seven states: Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, and Washington.

[10] Thirty-four states and the District of Columbia. *See, e.g.*, ALA. ADMIN. CODE r. 540-X-9-.11 (eff. 2000); ALASKA ADMIN. CODE tit. 12, § 40.967 (eff. 2000); ARIZ. REV. STAT. ANN. §§ 32-1401(27)(ss) (eff. 2000), -1501(31)(ww) (eff. 2003), 1854(48) (eff. 2000); 060.00.1 ARK. CODE R. § 2 (eff. date unclear); CONN. GEN. STAT. ANN. § 20-613a (eff. 2005); D.C. MUN. REGS. tit. 17, § 4616 (eff. 2012); DEL. CODE ANN. tit. 16, § 4744(c)(1) (eff. 2008); FLA. STAT. § 458.3265 (eff. 2011); GA. COMP. R. & REGS. 360-3-.02 (eff. date unclear); HAW. REV. STAT. ANN. § 329-1 (eff. 2008); 844 IND. ADMIN. CODE 5-4-1 (eff. 2003); IOWA ADMIN. CODE r.653-13.2(148,272C) (eff. date unclear); 201 KY. ADMIN. REGS. 8:540 (eff. 2012); LA. ADMIN. CODE tit. 46, pt. XLV, § 6921 (eff. 1997); 02-313 ME. CODE R.Ch. 21, § III (eff. 2010); MINN. R. 6500.0600 (eff. 1988); 30-17-2635 MISS. CODE R. §7.1 (eff. 2012); MO. REV. STAT. § 334.108 (eff. 2011); NEB. ADMIN. CODE § 172, Ch. 90, § 008 (eff. date unclear); NEV. ADMIN. CODE § 639.945 (eff. date unclear); N.H. REV. STAT. ANN. §318-B:1 (eff. 2011); N.J. ADMIN. CODE § 13:35-7.6(a) (eff. 2003); N.M. CODE R. § 16.10.8 (eff. 2003); 21 N.C. ADMIN. CODE § 46.1801(b) (eff. 2003); N.D. CENT. CODE § 19-02.1-15.1 (eff. 2009); OHIO ADMIN. CODE 4731-11-03 (eff. date

- **Indiana**
  "[A] physician shall not prescribe, dispense, or otherwise provide, or cause to be provided, any controlled substance to a person who the physician has never personally physically examined and diagnosed."[11]
- **South Carolina**
  Prior to prescribing a drug to an individual, a practitioner must "personally perform and document an appropriate history and physical examination . . . ."[12]

Sixteen states[13] and the District of Columbia[14] have laws that require an examination or evaluation that is deemed "appropriate" or some approximation of "sufficient," instead of or in addition to the physical examination laws.

- **California**
  Requires an "appropriate prior examination."[15]
- **Minnesota**
  Requires an "in-person examination" that is "adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment."[16]
- **New Jersey**
  When a practitioner prescribes a controlled substance, he or she must perform a physical examination "including an assessment of physical and psychological function, underlying or coexisting diseases or conditions, any history of substance abuse and the nature, frequency and severity of any pain."[17]

In some states dispensers are allowed to dispense prescriptions only if the prescription is prescribed by a practitioner who previously performed an adequate examination.

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unclear); OKLA. ADMIN. CODE § 435:10-7-11 (eff. 2005); 49 PA. CODE § 16.92(b)(1) (eff. 1986); R.I. GEN. LAWS § 21-28-3.24 (eff. 1974); S.C. CODE ANN. §§ 40-47-113 (eff. 1976); TENN. COMP. R. & REGS. 0880-02-.14(6)(e)(3)(i) (eff. 2001); 22 TEX. ADMIN. CODE § 170.3(a)(1), (7) (eff. 2007); UTAH ADMIN. CODE r. 156-37 (eff. date unclear); 18 VA. ADMIN. CODE § 85-20-25 (eff. date unclear); WASH. ADMIN. CODE §246-817-915 (eff. 2011).

[11] 844 IND. ADMIN. CODE 5-4-1 (eff. 2003).

[12] S.C. CODE ANN. §§ 40-47-113 (eff. 1976).

[13] *See, e.g.*, CAL. BUS. & PROF. CODE § 2242 (eff. 2000); CONN. AGENCIES REGS. § 21a-326-1 (eff. 1984); IDAHO CODE. ANN. § 54-1733; IOWA ADMIN. CODE r.650-16.2(153) (eff. date unclear); LA. REV. STAT. ANN. § 40:1238.4 (eff. 2007); MD. CODE REGS. 10.32.05.05 (eff. 2009); 234 MASS. CODE REGS. 9.05 (eff. date unclear); MINN. STAT. § 151.37 (eff. date unclear); 30-17-2635 MISS. CODE R. § 7.1 (eff. 2012); MO. CODE REGS. ANN. tit. 19§ 30-1.068 (eff. 2000); NEB. ADMIN. CODE § 172, Ch. 56, § 007 (eff. date unclear); NEV. ADMIN. CODE § 635.390 (eff. date unclear); N.J. ADMIN. CODE § 13:35-7.6 (eff. date unclear); N.M. CODE R. §16.5.57 (eff. date 2013); 22 TEX. ADMIN. CODE §§ 291.29 (eff. 2001); VT. STAT. ANN. tit. 18, § 9361 (eff. 2012).

[14] D.C. MUN. REGS. tit. 22-B, § 1300.7 (eff. 1986).

[15] CAL. BUS. & PROF. CODE § 2242 (eff. 2000).

[16] MINN. STAT. ANN. §§ 151.37 Subd. 2(d), (e) (eff. date unclear).

[17] N.J. ADMIN. CODE § 13:35-7.6 (eff. date unclear).

- **Missouri**
  "[p]rescriptions processed by any . . . pharmacy must be provided by a practitioner . . . who has performed a *sufficient physical examination* and clinical assessment of the patient."[18]

A few states simply require an examination before prescribing or dispensing controlled substances without giving specific standards for that examination.[19]

- **Montana**
  "[p]rescribing, dispensing or furnishing any prescription drug without a prior examination and a medical indication therefor," is unprofessional conduct.[20]

Applicability of Examination Requirement

Regardless of whether a state's physical examination law applies to prescribers or dispensers, and whether it requires a physical examination or more general examination or evaluation, the law might apply only to prescriptions for certain types of drugs or in specific circumstances.

Thirty-six states[21] and the District of Columbia[22] have physical examination laws that apply to prescriptions of all drug types or any prescription (includes controlled substances).

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[18] MO. CODE REGS. ANN. tit. 20, § 2220-2.020(11) (emphasis added) (eff. 2005).

[19] Ten states. *See, e.g.*, CAL. BUS. & PROF. CODE § 805.01 (eff. 2010); IDAHO ADMIN. CODE r. 23.01.01.315 (eff. 1999); IOWA ADMIN. CODE r. 650-16.3(153) (eff. date unclear); 201 KY. ADMIN. REGS. 20:057 (eff. 2012); MONT. ADMIN.R. 24.213.2301 (eff. 1998); NEB. ADMIN. CODE § 172, Ch. 120, § 010 (eff. date unclear); NEV. ADMIN. CODE §. 639.235 (eff. date unclear); N.J. ADMIN. CODE § 13:35-7.4 (eff. 2003); OR. REV. STAT. §677.190 (eff. date unclear); S.C. CODE ANN. § 40-47-965 (eff, date unclear).

[20] MONT. ADMIN .R. 24.213.2301(34) (eff. date unclear, prior to 1998).

[21] *See, e.g.*, ALA. ADMIN. CODE r. 540-X-9-.11 (eff. 2000); ALA. ADMIN. CODE r. 680-X-2-.33 (eff. 2006); ALASKA ADMIN. CODE tit. 12, § 40.967 (eff. date unclear); ARIZ. REV. STAT. ANN. §§ 32-1401(27)(ss), 32-1501(31)(ww), 32-1854(48) (eff. 2000); ARIZ. ADMIN. CODE § R4-23-110 (eff. 2000); ARK. CODE ANN. 17-92-1004(c) (eff. 2007); 070.00.7 ARK. CODE R. § 07-00-0009 (eff. 2007); CAL. BUS. & PROF. CODE § 805.01 (eff. 2010); CONN. GEN. STAT. ANN. § 20-613a (eff. 2005); CONN. AGENCIES REGS. § 21a-326-1(c) (eff. 1984); DEL. CODE ANN. tit. 16, § 4744(c)(1) (eff. 2008); FLA. STAT. ANN. § 465.023(1)(h) (eff. 2009); GA. CODE ANN. § 43-34-25 (eff date. unclear); HAW. REV. STAT. § 329-41 (eff. 2008); IDAHO CODE ANN. § 54-1733(1) (eff. 2006); 844 IND. ADMIN. CODE 5-4-1 (eff. 2003); IOWA CODE ANN. §§ 155A.27, 155A.13B (eff. 2009); KY. REV. STAT. ANN. § 218A.140(3) (eff. 2007); LA. ADMIN CODE. tit. 46, PT. XLVII, § 4513 (eff. date unclear); MD. CODE REGS.10.32.05.05 (eff. 2009); 234 MASS. CODE REGS. 9.05 (eff. date unclear); MINN. STAT. ANN. § 151.34 (eff. date unclear); 30-17-2635 MISS. CODE R. § 7.1 (eff. 2012); MO. CODE REGS. ANN. tit. 20, §§ 2220-2.020(9)(K), (11) (eff. 2005); NEB. ADMIN. CODE § 172, Ch. 56, § 007 (eff. date unclear); NEV. ADMIN. CODE § 639.945 (eff. 2001); N.H. REV. STAT. ANN. §§ 318-B:1(XXVI-a) (eff. 2011), -B:2(V)(e), -B:2(XII-b), -B:2(XII-c), -B:2(XII-e)(eff.2013), 329:1-c (eff. 2009), 329:17(VI)(I) (eff. 2009); N.J. ADMIN. CODE § 13:35-7.6(a) (eff. 2003); N.M. CODE R. § 16.10.8.8(L) (eff. 2001); 21 N.C. ADMIN. CODE 46.1806 (eff. 2003); N.D. CENT. CODE § 19-03.1-22.4 (eff. 2009); OHIO ADMIN. CODE 4730-2-07(B) (eff. 2007); OHIO ADMIN. CODE 4731-11-09(A) (eff. 1999); OKLA. ADMIN. CODE § 535:15-3-13(d) (eff. 2005); OR. REV. STAT. § 677.190 (eff. date unclear); 49 PA. CODE § 16.92(b)(1) (eff. 1986); S.C. CODE ANN. § 40-47-113 (eff. 2006); S.C. CODE ANN. § 44-117-340 (eff. 2007); TENN. COMP. R. & REGS. 1050-02-.13 (eff. 2001); 22 TEX. ADMIN. CODE § 190.8(1)(L) (eff. date unclear, 2003 or later); VT. STAT. ANN. tit. 18, § 9361 (eff. 2012); VA. CODE ANN. § 54.1-3303 (eff. 2000).

[22] D.C. MUN. REGS. tit. 22-B, § 1300.7 (eff. 1986).

- **Mississippi**
  "[P]roper prescribing and legitimate medical practice require . . . an appropriate physical . . . before prescribing any medication for the first time."[23]
- **Arkansas**
  An in-person physical examination "prior to the issuance of any prescription is required in order to establish a valid prior patient-practitioner relationship for purposes."[24]

A smaller number of states[25] and the District of Columbia[26] have laws that apply when using drugs or controlled substances for pain management treatment.

- **Oklahoma**
  Requires a physical examination where a physician prescribes medication to "treat a patient's intractable pain."[27]
- **Tennessee**
  Requires the physical examination prior to prescribing to include "an assessment and consideration of the pain" for which the controlled substance is being prescribed.[28]

Florida not only has physical examination laws for the prescribing and dispensing of all drugs, but also has physical examination laws specifically for pain management drugs.[29]

Fourteen states[30] have laws that apply only to specific controlled substances, schedules, or treatment of specific conditions.

- **Washington**
  A nurse practitioner must "obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic noncancer pain."[31]

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[23] 30-17-2635 MISS. CODE R. §7.1 (eff. 2012).
[24] 070.00.7 ARK. CODE R. § 07-00-0009 (eff. 2007).
[25] Thirteen states. *See, e.g.*, ALA. ADMIN. CODE r. 540-X-4-.08 (eff. 2000); FLA. STAT. § 458.3265 (eff. 2011); FLA. STAT. § 459.0137 (eff. 2011); FLA. ADMIN. CODE r. 64B8-9.013 (eff. 2010); IOWA ADMIN. CODE r. 653-13.2(148,272C) (eff. date unclear); 201 KY. ADMIN. REGS. 5:130 (eff. 2012); LA. REV. STAT. ANN. § 40:2198.12 (eff. 2005); LA. ADMIN. CODE tit. 46, pt. XLV, § 6921(A)(1) (eff. 1997); 02-313 ME. CODE R. Ch. 21, § III (eff. 2010); N.J. ADMIN. CODE § 13:35-7.6 (eff. date unclear); N.M. ADMIN. CODE 16.5.57 (eff. date unclear); OHIO ADMIN. CODE 4731-21-02 (eff. 2008); OKLA. CODE 435:10-7-11 (eff. 2005); OKLA. CODE 510:5-9-2 (eff. 1999); TENN. COMP. R. & REGS. 0880-02-.14 (eff. date unclear); 22 TEX. ADMIN. CODE § 170.3 (eff. 2001); WASH. ADMIN. CODE § 246-817-915 (eff. 2011).
[26] D.C. MUN. REGS. tit. 17, § 4616 (eff. 2012).
[27] OKLA. ADMIN. CODE § 510:5-9-2 (eff. 1999).
[28] TENN. COMP. R. & REGS. 0880-02-.14 (eff. date unclear).
[29] FLA. STAT. § 458.3265 (eff. 2010); FLA. STAT. § 459.0137 (eff. 2011); FLA. ADMIN. CODE r. 64B8-9.013 (eff. 2010).
[30] *See, e.g.*, 060.00.1 ARK. CODE R. § 2 (eff. date unclear); IOWA ADMIN. CODE r. 650-16.7(153) (eff. date unclear); IOWA ADMIN. CODE r. 653-23.1(272(C)) (eff. date unclear); 201 KY. ADMIN. REGS. 25:090 (eff. 2012); 201 KY. ADMIN. REGS. 9:260 (eff. 2012); LA. ADMIN CODE. tit. 46, pt. XLV, § 6921 (eff. 1997); MINN. STAT. §151.37 (eff. date unclear); MISS. CODE ANN. § 41-29-137 (eff. 2009)); NEV. ADMIN. CODE § 636.2882 (eff. date unclear); N.J. ADMIN. CODE § 13:35-7.4 (eff. 2003); OHIO ADMIN. CODE 4731-11-03 (eff. date unclear); OKLA. ADMIN. CODE § 510:5-9-2 (eff. 1999); R.I. GEN. LAWS §21-28-3.24 (eff. 1956); S.C. CODE ANN. § 44-53-360 (eff. date unclear); UTAH ADMIN. CODE r.156-37 (eff. date unclear); WASH. ADMIN. CODE § 246-840-467 (eff. 2011).
[31] WASH. ADMIN. CODE § 246-840-467 (eff. 2011).

- **Minnesota**
  Provides a list of substances, including certain schedules, for which "[a] prescription or drug order . . . is not valid, unless it can be established that the prescription or order was based on a documented patient evaluation, including an examination."[32]
- **Iowa**
  In addition to having regulations that concern pain management and prescribing controlled substances for any condition, sets an exam requirement for dentists to renew or refill emergency prescriptions for Schedule II controlled substances.[33]

Application with Reference to a Patient-Practitioner Relationship

Many states and the District of Columbia[34] have laws that require a physical examination by reference to a practitioner-patient relationship.[35] Some states do this by requiring a relationship between the practitioner and the patient, and then provide a definition of "practitioner-patient" or "physician-patient" (or some other similar combination) that includes a physical examination requirement elsewhere in statute or regulation.

- **Hawaii**
  "It shall be unlawful for any person . . . [to] prescribe . . . any controlled substance without a bona fide physician-patient relationship," and the definition of bona fide physician-patient relationship may be found in the definition section of the statute, including reference to a physical examination. [36]

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[32] MINN. STAT. § 151.37 (eff. date unclear).
[33] IOWA ADMIN. CODE r. 650-16.7(153) (eff. date unclear)."Emergency" here does not refer to a state of emergency declared by the government, but refers to circumstances wherein the prescriber is unable to provide a written prescription form immediately to the pharmacist so the pharmacist accepts an emergency oral prescription to avoid delay in providing necessary medications.
[34] D.C. MUN. REGS. tit. 22-B, § 1399 (eff. 2009).
[35] Twenty-three states. *See, e.g.*, ALASKA STAT. § 08.72.272 (eff. 2007); ALASKA ADMIN. CODE tit. 12, § 48.990 (eff. date unclear); ARIZ. ADMIN. CODE § R4-23-110 (eff. 2000); ARK. CODE ANN. 17-92-1004(c) (eff. 2007); CONN. GEN. STAT. ANN. § 20-613a (eff. 2005); DEL. CODE ANN. tit 16, § 4701 (eff. date unclear); FLA. STAT. ANN. § 465.023(1)(h) (eff. 2009); HAW. REV. STAT. § 329-1 (eff. 2008); HAW. REV. STAT. § 329-41 (eff. 2008); IDAHO ADMIN. CODE r. 23.01.01.315 (eff. 1999); KY. REV. STAT. ANN. § 218A.140; LA. ADMIN CODE. tit. 46, pt. XLV, § 7509 (eff. 2009); MO. REV. STAT. § 334.108 (eff. 2011); NEB. ADMIN. CODE § 172, Ch. 56, § 007 (eff. date unclear); NEV. ADMIN. CODE § 635.390 (eff. date unclear); N.H. REV. STAT. ANN. § 318-B:2 (eff. 2013); N.H. REV. STAT. § 318:52-a (eff. 2011); N.M. STAT. ANN. § 26-1-16(B) (eff. date unclear, 1987 or prior); N.M. CODE R. § 16.10.8 (eff. 2003); 21 N.C. ADMIN. CODE § 46.1801(b) (eff. 2003); N.D. CENT. CODE § 19-02.1-15.1 (eff. 2009); N.D. CENT. CODE § 19-03.1-22.4; OHIO ADMIN. CODE 4723-9-09 (eff. date unclear); OHIO ADMIN. CODE 4730-2-07 (eff. 2007); S.C. CODE ANN. § 40-47-113 (eff. 1976); S.C. CODE ANN. §§ 40-43-86; TENN. COMP. R. & REGS. 1050-02-.13 (eff. 2001); 22 TEX. ADMIN. CODE § 291.34 (eff. 2001); VT. ADMIN. CODE 20-4-1400:9.2 (eff. 2009); VA. CODE ANN. § 54.1-3434.1 (eff. 2008); 18 VA. ADMIN. CODE §§ 85-20-25.A, 85-50-176 (eff. 2005); 18 VA. ADMIN. CODE § 90-40-121 (eff. 2008); 18 VA. ADMIN. CODE §105-20-40 (eff. date unclear).
[36] HAW. REV. STAT. § 329-41; HAW. REV. STAT. § 329-1.

- **Kentucky**
  Requires "a valid practitioner-patient relationship" in one provision[37] and defines that to include a "good faith prior examination" in another provision, which is then further defined to include a physical examination.[38]
- **South Carolina**
  Requires a "proper physician-patient relationship," which it defines within the same provision to include "at a minimum . . . personally perform[ing] and document[ing] an appropriate history and physical examination."[39]

Application with Reference to a Valid Prescription

Several states[40] have physical examination laws stating that a *prescription is not valid* unless it is based on a physical examination or a valid practitioner-patient relationship.

- **Vermont**
  A prescription or order for a "legend drug is not valid unless it is issued for a legitimate medical purpose . . . which includes a documented patient evaluation."[41]

Application Specific to Prescriber or Dispenser

Thirty-eight states[42] and the District of Columbia[43] have physical examination laws that apply specifically to prescribers.[44]

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[37] KY. REV. STAT. ANN. § 218A.140.
[38] *Id.* §§ 218A.010 (14), (34).
[39] S.C. CODE ANN. § 40-47-113.
[40] Seven states. *See, e.g.*, CONN. GEN. STAT. ANN. § 20-613a (eff. 2005); IDAHO CODE ANN. § 54-1733 (eff. 2006); LA. ADMIN. CODE tit. 46, pt. LIII, § 2515(A) (eff. date unclear, 1989 or 2004); MINN. STAT. ANN. § 151.37 (eff. 2008); MISS. CODE ANN. § 41-29-137; N.D. CENT. CODE § 19-03.1-22.4; VT. ADMIN. CODE 20-4-1400:9.2 (eff. 2009).
[41] VT. ADMIN. CODE 20-4-1400:9.2 (eff. 2009). "Legend drugs" refer to prescription-only drugs in the United States.
[42] *See, e.g.*, ALA. ADMIN. CODE r. 540-X-9-.11 (eff. 2000); ALASKA ADMIN. CODE tit. 12, § 40.967 (eff. date unclear); ALASKA STAT. § 08.72.272 (eff. 2007); ARIZ. ADMIN. CODE § R4-19-511(eff. 2005); 070.00.7 ARK. CODE R. § 07-00-0009 (eff. 2007); CAL. BUS. & PROF. CODE § 2242(a) (eff. 1981); CAL. BUS. & PROF. CODE § 2242.1(a) (eff. 2000); CAL. BUS. & PROF. CODE § 3110 (eff. 2005); CONN. AGENCIES REGS. § 21A-326-1 (eff. 1984); DEL. CODE ANN. tit. 16, § 4701 (eff. date unclear); FLA. STAT. § 456.44 (eff. 2011); GA COMP. R. & REGS. 360-3-.02 (eff. date unclear);HAW. REV. STAT. § 329-41(b) (eff. 2008); IDAHO ADMIN. CODE r.23.01.01.31 (eff. 1999); 844 IND. ADMIN. CODE 5-4-1 (eff. 2003); IOWA ADMIN. CODE r. 650-16.3(153) (eff. date unclear); 201 KY. ADMIN. REGS. 25:090 (eff. 2012); LA. ADMIN CODE. tit. 46, pt. XLV, § 6921 (eff. 1997); MD. CODE REGS.10.40.11.04 (eff. 2012); 234 MASS. CODE REGS. 9.05 (eff. date unclear); MINN. R. 6500.0600 (eff. 1988); MISS. ADMIN. CODE 30-17-2635:7.1 (eff. date 2012); MO. CODE REGS. ANN. tit. 19, § 30-1.068 (eff. 2000); MONT. ADMIN. R. 24.213.2301 (eff. 1998); NEB. ADMIN. CODE § 172, Ch. 56, § 007; NEV. ADMIN. CODE § 636.2882 (eff. date unclear); N.H. REV. STAT. ANN. §§ 318-B:1(XXVI-a) (eff. 2009); N.J. ADMIN. CODE § 13:35-7.2 (eff. date unclear); N.M. CODE R. § 16.10.16 (eff. date unclear); OHIO ADMIN. CODE 4730-2-07 (eff. 2007); OKLA. ADMIN. CODE § 510:5-9-2 (eff. date 1999); OR. ADMIN. R. 852-060-0025 (eff. date unclear); 49 PA. CODE § 16.92(b)(1) (eff. 1986); R.I. GEN. LAWS § 21-28-3.24 (eff. 1974); S.C. CODE ANN. § 40-47-965 (eff. date unclear); TENN. COMP. R. & REGS. 1000-04-.09 (eff. date unclear); 22 TEX. ADMIN. CODE § 190.8; UTAH ADMIN. CODE r.156-37 (eff. date unclear); VT. ADMIN. CODE 20-4-1400:9.2 (eff. 2009); VA. CODE ANN. § 54.1-3303(B) (eff. 2000); WASH. ADMIN. CODE § 246-817-915 (eff. 2011).
[43] D.C. MUN. REGS. tit. 17, § 4616 (eff. 2012).

- **Alabama**
  Requires that "the physician personally perform an appropriate history and physical examination" prior to prescribing.[45]
- **Alaska**
  Applies physical examination requirements to optometrists who prescribe controlled substances in addition to other prescribers.[46]

Twenty-seven states,[47] and the District of Columbia,[48] have physical examination laws that apply specifically to dispensers.

- **Delaware**
  Applies a requirement to internet pharmacies who act to dispense any prescription drug, including controlled substances, stating that the pharmacy may only dispense if "the practitioner issuing the prescription drug order to be filled or dispensed by the Internet pharmacy is a licensed practitioner" who has examined a Delaware patient." [49]

Frequently, as in the New Jersey regulation, the physical examination requirement applies directly to the practitioner either dispensing or prescribing.

- **New Jersey**
  "[A] practitioner shall not dispense drugs or issue prescriptions to an individual . . . without first having conducted an examination . . . ."[50]

A few states[51] and the District of Columbia[52] also require the dispenser to have knowledge that the patient and prescriber have a valid practitioner–patient relationship prior to dispensing a controlled substance.

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[44] Many of these thirty-eight states and the District of Columbia also have physical examination laws that apply to dispensers.
[45] ALA. ADMIN. CODE r. 540-X-9-.11 (eff. 2000).
[46] ALASKA STAT. § 08.72.272 (eff. 2007).
[47] *See, e.g.*, ALASKA ADMIN. CODE tit. 12, § 40.967 (eff. 2000); ARIZ. ADMIN. CODE § R4-19-511(eff. 2005); CAL. BUS. & PROF. CODE § 2242 (eff. 2000); CONN. AGENCIES REGS. § 21a-326-1 (eff. 1984); DEL. CODE ANN. tit. 16, § 4744(a)(1) (eff. 2008); HAW. REV. STAT. § 329-41 (eff 2008); HAW. REV. STAT. § 329-1 (eff. 2008); IDAHO ADMIN. CODE r. 23.01.01.315 (eff. 1999); 844 IND. ADMIN. CODE 5-3-2 (eff. 2003); IOWA ADMIN. CODE r. 650-16.3(153) (eff. date unclear); LA. REV. STAT. ANN. § 40:1238.4(eff. 2007); MINN. STAT. § 151.34 (eff. 1988); MISS. CODE ANN. § 41-29-137 (eff. date unclear); MONT. ADMIN .R. 24.213.2301(34) (eff. 1998); NEV. ADMIN. CODE § 639.945(1)(n) (eff. 2001); N.H. REV. STAT. § 318-B:2 (eff. 2013); N.J. ADMIN. CODE § 13:35-7.1A (eff. 2003); N.M. STAT. ANN. § 26-1-16 (eff. 1978); 21 N.C. ADMIN. CODE 46.1801 (eff. date 2003); N.D. CENT. CODE § 19-02.1-15.1 (eff. 2009); OHIO ADMIN. CODE 4731-11-09 (eff. 1999); 49 PA. CODE § 16.92(b)(1) (eff. 1986); S.C. CODE ANN. § 40-43-86 (eff. date unclear); TEX. OCC. CODE ANN. § 562.056 (eff. 2005).
[48] D.C. MUN. REGS. tit. 22-B, § 1300 (eff. 1986).
[49] DEL. CODE ANN. tit. 16, § 4744(a)(1).
[50] N.J. ADMIN. CODE § 13:35-7.1A.

- **Nevada**
  "Dispensing a drug as a dispensing practitioner to a patient with whom the dispensing practitioner does not have a bona fide therapeutic relationship" is unprofessional conduct.[53] In another provision, the law states that "a bona fide therapeutic relationship between the patient and practitioner shall be deemed to exist . . . [i]f the patient was physically examined by the practitioner within the [six] months immediately preceding the date the practitioner dispenses or prescribes a drug to the patient."[54]
- **Louisiana**
  Applies a knowledge standard to dispensing pharmacists, stating that "[a] pharmacist who *knows* that a prescription has been authorized in the absence of a valid physician-patient relationship . . . shall not fill such prescription."[55] Another provision defines that relationship to include "at least one medical evaluation with a person in the physical presence of the practitioner, without regard to whether portions of the evaluation are conducted by other practitioners."[56]

Electronic Questionnaires

Many states,[57] and the District of Columbia,[58] that require examinations before prescribing have also enacted provisions prohibiting practitioners from prescribing based solely on electronic patient questionnaires.

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[51] Five states. *See, e.g.,* DEL. CODE ANN. tit. 16, § 4744(a)(1); LA. REV. STAT. ANN. § 40:1238.4 (eff. 2007); NEV. ADMIN. CODE § 639.945(1)(n) (eff. 2001)); N.H. REV. STAT. ANN. § 318-B:2 (eff. date 2013); N.H. REV. STAT. ANN. § 329:1-c (eff. date 2009); 21 N.C. ADMIN. CODE 46.1801 (eff. date 2003).
[52] D.C. MUN. REGS. tit. 22-B, § 1300 (eff. 1986).
[53] NEV. ADMIN. CODE § 639.945(1)(n)
[54] *Id*. at § 639.945(3) (eff. 2001).
[55] LA. REV. STAT. ANN. § 40:1238.4(D) (emphasis added).
[56] *Id.* at § 40:1238.4(A)(2) (eff. 2007).
[57] Twenty-five states. *See, e.g.*, ALA. ADMIN. CODE r. 540-X-9-.11(3) (eff. 2000); ALASKA ADMIN. CODE tit. 12, § 40.967 (eff. date unclear); ARIZ. REV. STAT. ANN. §§ 32-1401 (eff. 2000); ARK. CODE ANN. § 17-92-1004 (eff. 2007); CAL.BUS. & PROF.CODE § 2242.1 (eff. 2000); CAL.BUS. & PROF.CODE § 4067 (eff. 2000); CONN. GEN. STAT. ANN. § 20-613a (eff. 2005); DEL. CODE ANN. tit. 16, § 4744(c)(1) (eff. 2008); FLA. ADMIN. CODE r. 64B8-9.014 (eff. 2003); FLA. ADMIN. CODE r. 64B15-14.008 (eff. date unclear); GA. COMP. R. & REGS. 360-3-.02 (eff. date unclear); IDAHO CODE ANN. § 54-1733(1) (eff. 2006); 844 IND. ADMIN. CODE 5-3-2 (eff. 2003); LA. REV. STAT. ANN. § 40:1238.4 (eff. 2007); LA. ADMIN CODE. tit. 46, pt. XLV, § 7505 (eff. 2009); LA. ADMIN CODE. tit. 46, pt. XLV, § 7509 (eff. 2009); LA. ADMIN CODE. tit. 46, pt. XLVII, § 4513 (eff. date unclear); MD. CODE REGS.10.32.05.05 (eff. 2009); 234 MASS. CODE REGS. 9.05 (eff. 1995); MISS. CODE ANN. § 41-29-137 (eff. 2009); 30-17 MISS. CODE R. § 2635:7.1 (eff. 2012); MO. REV. STAT. § 334.108 (eff. 2011); NEB. ADMIN. CODE § 172, Ch. 56, § 007 (eff. date unclear); NEB. ADMIN. CODE § 172, Ch. 90, § 008 (eff. date unclear); NEV. ADMIN. CODE § 453.3643 (eff. date unclear); NEV. ADMIN. CODE § 630A.144 (eff. 2003) ; N.H. REV. STAT. § 318-B:2 (eff. 2013); N.D. CENT. CODE § 19-02.1-15.1 (eff. 2009); N.D. CENT. CODE § 19-03.1-22.4; 22 (eff. 2009); S.C. CODE ANN. § 40-47-113 (eff. 2006); TENN. COMP. R. & REGS. 1000-04-.09 (eff. date unclear); TEX. ADMIN. CODE § 190.8(1)(L)(i)(II) (eff. date unclear, 2003–12); 22 TEX. ADMIN. CODE 22, § 291.29 (eff. 2001); VT. STAT. ANN. tit. 18, § 9361 (eff. 2012); VA. CODE ANN. § 54.1-3434.1 (eff. 2008).
[58] D.C. MUN. REGS. tit. 22-B, § 1300.7 (eff. 1986).

- **Louisiana**
  "A prescription issued solely upon the results of answers to an electronic questionnaire, in the absence of a documented patient evaluation including a physical examination, shall be considered issued outside the context of a valid physician-patient relationship and shall not be a valid prescription."[59]
- **Connecticut**
  Declares a prescription that is not based on a physical examination and "issued solely on the results of answers to an electronic questionnaire shall be considered to be issued outside the context of a valid practitioner-patient relationship and not be a valid prescription."[60]
- **Nebraska**
  Allows disciplinary action against a prescriber who issues "a prescription, via electronic or other means, unless the physician has obtained a history and physical evaluation of the patient."[61]
- **New Hampshire**
  Has a physical examination law that applies when controlled substances are delivered by mail and provides that "[i]t shall be unlawful for any pharmacy to ship finished prescription products . . . to patients . . . that w[ere] generated based upon the patient's submission of an electronic or online medical history form." [62] The law also states that "[s]uch electronic or online medical questionnaires, even if followed by telephonic communication between practitioner and patient, shall not be deemed to form the basis of a valid practitioner-patient relationship."[63] This law is similar to other laws prohibiting prescribing and dispensing based on electronic questionnaires but applies only to the *shipping* of the drugs.

Conclusion

This inventory compiles state physical examination requirements for prescribing and dispensing controlled substances. This inventory does not contain a full assessment of all relevant prescription drug laws. Practitioners should consult with legal counsel to become fully informed of the legal landscape concerning prescription drugs and how the laws are implemented and enforced in their state.

This document was written by researchers in the Public Health Law Program (PHLP), Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention (CDC),[64] with assistance from the Division of Unintentional Injury Prevention in CDC's National Center for Injury Prevention and Control.[65] For further technical assistance with this inventory or prescription drug laws, please contact

[59] LA. REV. STAT. ANN. § 40:1238.4(B) (eff. 2007);
[60] CONN. GEN. STAT. ANN. § 20-613a (eff. 2005).
[61] NEB. ADMIN. CODE § 172, Ch. 90, § 008 (eff. date unclear).
[62] N.H. REV. STAT. ANN. § 318-B:2(XII-d) (eff. 2013).
[63] *Id.* "Practitioner-patient" relationship is defined to require an in-person exam. *See* N.H. REV. STAT. § 318-B:1 (eff. 2011).
[64] Catherine Clodfelter, JD, MPH, Akshara Menon, JD, MPH, Carla Chen, JD, and Matthew Penn, JD, MLIS. We thank Rina Lieberman, JD, MPH, for her research assistance.
[65] Noah Aleshire, JD, and Leonard Paulozzi, MD, MPH.

PHLP.[66] For technical assistance on all other opioid pain reliever-related topics, please contact CDC's Division of Unintentional Injury Prevention.[67]

PHLP provides technical assistance and public health law resources to advance the use of law as a public health tool. PHLP cannot provide legal advice on any issue and cannot represent any individual or entity in any matter. PHLP recommends seeking the advice of an attorney or other qualified professional with questions regarding the application of law to a specific circumstance. The findings and conclusions in this summary are those of the author and do not necessarily represent the official views of CDC.

This menu includes laws enacted through December 4, 2013.

Published January 29, 2015.

[66] Public Health Law Program, Centers for Disease Control and Prevention, 4770 Buford Hwy. NE, MS E-70, Atlanta, GA 30341. Telephone: (404) 498-0470. Fax: (404) 498-6882. Email: mpenn@cdc.gov. Web: http://www.cdc.gov/phlp.

[67] Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Hwy. NE, MS F-62, Atlanta, GA 30341. Email: lbp4@cdc.gov. Web: http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/laws/index.html.

Joint Statement on Antibiotic Resistance from 25 National Health Organizations and the Centers for Disease Control and Prevention

Alliance for the Prudent Use of Antibiotics

American Academy of Pediatrics

American Academy of Physician Assistants

American Academy of Urgent Care Medicine

American Medical Directors Association

American Public Health Association

American Society of Health System Pharmacists

Association for Professionals in Infection Control and Epidemiology, Inc.

Association of State and Territorial Health Officials

Center for Disease Dynamics, Economics & Policy

Centers for Disease Control and Prevention

Consumers Union

Council of State and Territorial Epidemiologists

Infectious Diseases Society of America

Institute for Healthcare Improvement

Since their introduction into medicine in 1941, antibiotics have saved millions of lives and transformed modern medicine. As a result, bacterial infections have become easily treatable, and the horizons for surgeries, transplants, and more complicated life-saving procedures have expanded. But increasing antibiotic resistance is leading to higher treatment costs, longer hospital stays, and unnecessary deaths.

The more we use antibiotics, the more we contribute to the pool of antibiotic-resistant microbes. The development of resistance is an inevitable byproduct of exposure to antibiotics. All antibiotic use, whether warranted or not, places selection pressure on bacteria, and some organisms that possess genetic mutations will survive antibiotic treatment. Over time, resistance threatens to return us to an era where simple bacterial infections will once again be deadly.

As representatives from a range of fields concerned with human health, we jointly recognize our collective responsibility to protect the effectiveness of all antibiotics – those we have today, and those yet to be developed. We also recognize the potential for these life-saving drugs to be overused in both the human and agricultural sectors. Antibiotics are a shared resource, and every individual should consider how each prescription or use of antibiotics affects the overall effectiveness of the antibiotic arsenal. The problem is defined by challenges on both the demand and supply sides of the equation – just as antibiotics are frequently overused, there are few new drugs in the development pipeline.

Understanding this situation, we jointly commit to the following principles to both conserve and replenish our antibiotic resources:

- To seek greater coordination among all stakeholders in antibiotic effectiveness, including healthcare personnel, hospital administrators, policymakers, patients, and individuals working in medical centers, universities, and pharmaceutical companies to promote knowledge sharing and a mutual commitment to improving antibiotic use, a practice referred to as antibiotic stewardship
- To work towards optimizing antibiotic use through antibiotic stewardship programs and interventions, which help ensure that patients get the right antibiotics at the right time for the right duration

National Association of County and City Health Officials

National Association of Directors of Nursing Administration in Long Term Care

National Association of Public Hospitals

Pediatric Infectious Disease Society

Public Health Foundation

Robert Wood Johnson Foundation

Society of Hospital Medicine

The Pew Charitable Trusts

The Society for Healthcare Epidemiology of America

The Society of Infectious Diseases Pharmacists

Trust for America's Health

- To identify the most effective examples of antimicrobial stewardship and to replicate these strategies and best practices, while also taking into account local context
- To support research that deepens our understanding of the current situation and trends in antibiotic resistance and use
- To use information about the drivers of antibiotic use to contribute to the evolving definition of "appropriate antibiotic use," and to use this definition to guide stewardship efforts, including the education of the general public and healthcare personnel at all levels
- To improve surveillance for drug-resistant infections and to encourage reporting activities in a way that supports both positive outcomes and accuracy
- To encourage the development of pharmaceutical products to combat antibiotic resistance, including new antibiotics or novel therapies, compounds to boost antibiotic effectiveness, diagnostics to better diagnose infections and their resistance characteristics, and vaccines to prevent infections from occurring
- To recognize that antibiotic resistance is one of the world's most pressing public health threats and that global collective action is required to effectively address the challenge of managing our scarce supply of effective antibiotics
- To acknowledge that the way we use antibiotics today in patients impacts how effective they will be in the future in other patients
- To communicate that antibiotic resistance is an infectious disease and public health concern: some resistant bacteria have the potential to spread rapidly from person to person, which increases the threat of resistant infections
- To work with regulatory, veterinary and industry partners to promote the judicious use of antibiotics in food animals
- To reinforce the judicious use of antibiotics in agriculture by: limiting the use of medically important human antibiotics in food animals; supporting the use of such antibiotics in animals only for those uses that are considered necessary for assuring animal health; and having veterinary oversight for such antibiotics used in animals

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

CDC Encourages Safe Antibiotic Prescribing and Use

Be Antibiotics Aware: protect patients now and fight antibiotic resistance

Press Release

For Immediate Release: Wednesday, November 15, 2017

Contact: Media Relations (https://www.cdc.gov/media)
(404) 639-3286

November 13, 2017, kicked off U.S. Antibiotic Awareness Week and World Antibiotic Awareness Week. The Centers for Disease Control and Prevention (CDC) recognizes this week with an updated educational effort, *Be Antibiotics Aware: Smart Use, Best Care* (https://www.cdc.gov/antibiotic-use/week/index.html), to support the nation's efforts to combat antibiotic resistance through improved use of these life-saving medications.

Each year, at least 2 million Americans become infected with antibiotic-resistant bacteria, and at least 23,000 people die as a result. As part of U.S. Antibiotic Awareness Week, the Department of Health and Human Services (HHS), on behalf of the Interagency Combating Antibiotic Resistant Bacteria (CARB) Task Force, has released a Progress Report (https://aspe.hhs.gov/pdf-report/national-action-plan-combating-antibiotic-resistant-bacteria-progress-report-years-1-and-2) to detail the significant progress during the first two years of implementation of the National Action Plan for Combatting Antibiotic-Resistant Bacteria (https://www.cdc.gov/drugresistance/pdf/national_action_plan_for_combating_antibotic-resistant_bacteria.pdf).

"Antibiotic resistance is a critical public health concern, and this educational effort is an excellent opportunity to drive change in improving antibiotic use, give doctors the tools they need to improve antibiotic prescribing, and help patients better protect their health," said CDC Director Brenda Fitzgerald, M.D.

Prescribing the right antibiotic at the right time, in the right dose, and for the right duration helps fight antibiotic resistance, protects patients from unnecessary side effects, and helps ensure these life-saving medicines will be available for future generations.

Though the United States has made progress toward optimal prescribing and use of antibiotics for patients, there is still room for improvement. The *Be Antibiotics Aware* effort helps inform healthcare professionals and patients about proper antibiotic use and encourages open discussion among doctors and patients.

Antibiotics are critical tools for treating a number of common infections, such as pneumonia, and for life-threatening conditions including sepsis. However, when patients take antibiotics unnecessarily, they are at risk for side effects and get no benefit from the drugs. Minor side effects can include rash, dizziness, nausea, diarrhea, and yeast infections. Major side effects can include allergic reactions and *Clostridium difficile* (*C. difficile* or C. diff) infection, which can cause severe diarrhea and colon damage and can cause death.

"Despite prescribing guidelines, some healthcare professionals report giving antibiotics when they aren't needed because of fear of misdiagnosis or pressure from patients," said Lauri Hicks, D.O., director, Office of Antibiotic Stewardship, Division of Healthcare Quality Promotion, CDC. "CDC encourages healthcare professionals and patients to talk through the best ways to feel better and what treatment options are most effective."

The *Be Antibiotics Aware* educational effort also aligns with antibiotic stewardship activities mentioned in the National Action Plan for Combating Antibiotic Resistant Bacteria (CARB), (https://obamawhitehouse.archives.gov/sites/default/files/docs/national_action_plan_for_combating_antibotic-resistant_bacteria.pdf) supports the National Action Plan to Prevent Health Care-Associated Infections (HAIs): Road Map to Elimination (https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/national-action-plan-prevent-health-care-associated) , and complements other patient safety initiatives, such as the *Get Ahead of Sepsis* education effort launched in August 2017.

There are many ways to get involved in U.S. Antibiotic Awareness Week 2017. Visit www.cdc.gov/antibiotic-use (http://www.cdc.gov/antibiotic-use) to learn more about how to participate.

CDC is a global leader in efforts to improve antibiotic prescribing and use practices. Read more about Antibiotic Use in the United States, including progress and opportunities (https://www.cdc.gov/antibiotic-use/stewardship-report/index.html). These efforts are supported by CDC's Antibiotic Resistance Solutions Initiative (https://www.cdc.gov/drugresistance/solutions-initiative/index.html). To learn more about antibiotic resistance, visit www.cdc.gov/drugresistance (http://www.cdc.gov/drugresistance).

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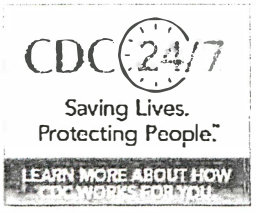
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (http://www.hhs.gov/)



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How do I view different file formats (PDF, DOC, PPT, MPEG) on this site? (https://www.cdc.gov/Other/plugins/)

(https://www.cdc.gov/Other/plugins/#pdf)

Page last reviewed: November 15, 2017

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ATTACHMENT 4

Testimony of Dr. Brenda Miller
Member of the North Dakota Board of Medicine

Chairman Devlin, and the Administrative Rules Committee my name is Brenda Miller, I am a licensed physician in the state of North Dakota and a member of the North Dakota Board of Medicine.

I appear before you today to address the comments we received in response to our telemedicine rule regarding the development of the patient-licensee relationship and more specifically the interactive video requirement. I realize that this portion of our rule has some opposition. I hope I can help you all understand why the board believes this portion of our rule is very important.

In the beginning conversations of this rule, our Board was insistent that there needed to be a visual examination either in person, through video or using another properly licensed individual. Our board believes that when establishing a new patient licensee relationship, the physician needs to be able to see the patient.

Visual observation is especially important during a psychological exam. The provider will want to see if the patient exhibits restlessness, darting eyes, mouth movements, trunk movements as these are all signs of potential problems that need to be addressed properly.

Visual observation is equally important in pediatric care. The pediatrician will want to see if the patient is irritable or smiling, if the patient is consolable, if the patient is flushed or has a rash, if the patient appears hydrated, when they cry do they have tears etc.

Visual observation of elderly patients provides the physician with valuable information as well. It is important to see if the patient is able to ambulate on their own. Are they able to answer questions without assistance from a loved one?

When considering prenatal care visual observation is also extremely valuable. It would not be within the standard of care to make any decisions without being able to listen to the fetal heart tones.

The requirements established within this rule by our board help ensure that the standard of care is being met. In traditional medicine physicians have been able to provide follow up care through a phone call. There has always been an acceptance of the ability to see a patient in the office and then receive a phone call from them to discuss the care if something needed to be addressed. However, it would have never been acceptable or within the standard of care to receive a cold call from an unknown patient who was referred to you and to diagnose and treat them based on a phone call or an email. This is what we are attempting to avoid. With the introduction of what we now call telemedicine we have an obligation to provide parameters that everyone understands to define a new encounter between a patient and a doctor who is unknown to them.

To allow diagnosis and treatment to occur between a patient and a new doctor based on only a telephone call and a questionnaire leaves the public exposed to misdiagnosis due to a lack of proper evaluation. It also may contribute to the over prescription of antibiotics which is currently one of the CDC's major concerns.

The ultimate goal is patient safety by assuring the standard of care is not altered by the type of visit.

Chairman Devlin called on Mr. Dustin Peyer for comments. Mr. Peyer said because of his grandmother's medical issues, he has been personally affected by the need for medical marijuana. He said the medical marijuana program may want to consider the impact of the legalization of recreational marijuana on the medical marijuana program.

Chairman Devlin said the State Department of Health only has the authority to deal with laws that have passed.

Chairman Devlin called on Mr. Paul Aughinbaugh, Fargo, for comments. Mr. Aughinbaugh said he is a potential dispensary applicant. He said if recreational marijuana is legalized, he is concerned about what would happen to a dispensary that has paid over $90,000 for certification.

Mr. Wahl said the department's only duty is to implement the medical marijuana program. He said the program is being implemented based upon the law passed by the Legislative Assembly in 2017. He said the department will implement the medical marijuana program as timely as possible. Regarding dispensaries located in cities, he said to ensure access to as many people as possible with as little travel as possible, an eight-region map has been created. He said the map is on the department's website. He said one dispensary in each of those eight regions is expected. He said dispensaries are permitted to offer home delivery.

In response to a question from Senator Heckaman, Mr. Wahl said local zoning officials will be provided a form to sign to confirm the dispensary facility complies with local zoning requirements.

In response to a question from Senator Klein, Mr. Wahl said the dispensary fee is set in state law. He said the law does not include a provision for a refund if the recreational marijuana measure passes.

In response to a question from Senator Heckaman, Mr. Wahl said the program's registration and application fees will be deposited in the Bank of North Dakota in the same way as any other state program.

NORTH DAKOTA BOARD OF MEDICINE

Chairman Devlin called on Ms. Bonnie Storbakken, Executive Director, North Dakota Board of Medicine, for testimony (Appendix E) regarding rules relating to telemedicine carried over from the December 5, 2017, meeting.

In response to a question from Chairman Devlin, Ms. Storbakken said Teladoc was not invited to sit down with the board to discuss the face-to-face consultation requirement.

Chairman Devlin called on Dr. Brenda Miller, North Dakota Board of Medicine, for testimony (Appendix F) regarding the telemedicine rule.

In response to a question from Representative Pyle, Dr. Miller said a physician should not give advice without establishing a relationship.

Chairman Devlin called on Mr. John Ward for testimony (Appendix G) regarding the telemedicine rules. Mr. Ward said he represents Teladoc. He said interactive audio is used in every state. He said the physician has the ability to request high-resolution photos. He said interactive audio is an acceptable telemedicine tool used across the country. He said the North Dakota Board of Medicine conducted open meetings regarding the carried over telemedicine rules but did not give the public an opportunity to speak. He said telemedicine consultations are done by physicians who are licensed by the board. He said Teladoc has not experienced malpractice claims as a result of its practices. He said Arkansas is the only other state with a face-to-face consultation requirement. He said the Minnesota standard of care for telemedicine is the same as for inpatient care.

In response to a question from Representative Koppelman, Mr. Ward said if a physician who uses interactive audio is unable to diagnose a patient using that method, the physician is expected to advise the patient to make an appointment for an in-person visit with the patient's health care provider.

Chairman Devlin called on Mr. Jack McDonald for testimony regarding the telemedicine rule. Mr. McDonald distributed a letter (Appendix H) from America's Health Insurance Plans (AHIP) regarding concerns about the changes being proposed by the North Dakota Board of Medicine. He said AHIP believes the rules fail to consider the evolving nature of telemedicine technology and limit a patient's options when deciding on the best course of action to obtain health care.

Representative Koppelman said he understands the board's obligation to protect the public. He said telemedicine is defined in North Dakota Century Code (NDCC). He said the board has indicated it will not change its position on the face-to-face requirement. He said it is important to stay current with technology. He said the

board followed the committee's directive regarding the prescribing of opioids for medication-assisted treatment situations.

It was moved by Representative Koppelman, seconded by Senator Kilzer, and carried on a roll call vote to:

1. **Adopt the changes to the opioid restriction as proposed by the North Dakota Board of Medicine;**
2. **Retain the definitions contained in North Dakota Administrative Code (NDAC) Section 50-02-15-01 on page 215 of Supplement 368; and**
3. **Void NDAC Sections 50-02-15-02 and 50-02-15-03 on the finding that, under NDCC Section 28-32-18 (1) (c)(d)(e), the rules failed to comply with express legislative intent; are in conflict with state law; and are arbitrary and capricious.**

Representatives Devlin, Boehning, Boschee, Koppelman, Louser, Pyle, Schneider, Seibel, Toman, and Weisz and Senators Anderson, Armstrong, Heckaman, Kilzer, Klein, Meyer, Poolman, and Rust voted "aye." No negative votes were cast.

Representative Koppelman said the North Dakota Board of Medicine should start over on the telemedicine rules.

Senator Kilzer said telemedicine is needed now more than ever. He said the hands-on medicine is being done more and more by nonphysicians such as physician's assistants and nurse practitioners. He said the requirements for telemedicine are a policy decision for the Legislative Assembly. He said third-party coverage is an issue insurance companies continue to face without resolution. He said another issue is the crossing of state boundaries when providing medical consultations. He said a study of telemedicine is needed.

BOARD OF EXAMINERS ON AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

Chairman Devlin called on Ms. Kelli Ellenbaum, Chairperson, Board of Examiners on Audiology and Speech-Language Pathology, for testimony (Appendix I) regarding April 2018 rules adopted by the board.

Senator Poolman said she appreciated the efforts of the board to increase the number of licensees in the workforce.

In response to a question from Representative Pyle, Ms. Ellenbaum said the University of North Dakota has space for 22 students in its program. She said many of the licensees practicing in the state have degrees from Minot State University and Minnesota State University - Moorhead. She said the University of Mary is in the process of establishing a graduate program in audiology and speech-language pathology.

In response to a question from Representative Schneider, Ms. Ellenbaum said the board is prepared for the extra workload that will result from the increasing number of graduates in the state. She said there are 400 to 600 open positions in the state. She said the shortage creates heavy caseloads for licensees.

In response to a question from Representative Weisz, Ms. Ellenbaum said Blue Cross Blue Shield covers the services of speech-language pathology assistants but most third-party payers require a licensed speech-language pathologist to sign off if the work is done by licensed assistants.

In response to a question from Senator Kilzer, Ms. Ellenbaum said fully trained speech-language pathologists and assistants are in high demand.

In response to a question from Representative Boehning, Ms. Ellenbaum said increasing the number of program slots at the colleges in the state is not enough to meet the demand. She said the colleges that offer the degree are experiencing a shortage of professors to teach the required courses.

Senator Anderson said it is difficult to get the North Dakota University System to increase faculty without increased funding.

INDUSTRIAL COMMISSION

Chairman Devlin called on Mr. Bruce Hicks, Assistant Director, Oil and Gas Division, Industrial Commission, for testimony (Appendix J) regarding April 2018 rules adopted by the Industrial Commission.

In response to a question from Senator Rust, Mr. Hicks said the delayed effective date of July 1, 2019, for the rules will give the industry time to make necessary software updates. He said the date also gives the Legislative Assembly the opportunity to make changes during the 2019 legislative session, if necessary.

Madam Chair and members of the Senate Human Services Committee my name is Brenda Miller I am licensed physician in the state of North Dakota and a member of the North Dakota Board of Medicine.

I appear before you today to provide some context behind the Board's language regarding the development of the patient-licensee relationship. I realize that this portion of our bill has some opposition. I hope I can help you all understand why the board believes this language is important.

When the Board initially began drafting this as a rule, our Board was insistent that there needed to be a visual examination either in person, through video or using another properly licensed individual. Our board believes that **when establishing a new** patient- licensee relationship, the physician or another provider working with the physician needs to be able to see the patient. I would like to make it clear that this section applies to the establishment of a new patient-licensee relationship via telemedicine and not to the use of telemedicine with an already established patient. There are many reasons our Board believes that having visual observation is necessary in the instance of treating a new patient.

Visual observation is an important factor when verifying the patient's identity and age. The patient also has the ability to confirm they are in fact being treated by licensed providers. Without this, there is potential for the physician to be treating a patient that is not the age they represent or who they represent. There is also potential for the patient to be giving their medical information to someone who is not a licensed or qualified provider. Our Board has received complaints of this nature. In one instance, a patient was unsure of the identity of the person representing themselves as a physician on the other end of the phone line and email. Another complaint involved patients receiving cold calls asking them about pain medication and then receiving pain medication in the mail. Unfortunately, these things happen and it is the purpose of this Board to protect the public from these situations. The Board believes with this bill it can best protect the public from situations like these.

Visual observation is especially important during a psychological exam. The provider will want to see if the patient exhibits restlessness, darting eyes, mouth movements, and trunk movements as these are all signs of potential problems that need to be addressed properly.

Visual observation is equally important in pediatric care. The pediatrician will want to see if the patient is irritable or smiling or if the patient is consolable etc. It is also important to see if the patient is flushed or has a rash. A provider will also need to see if the patient appears hydrated, and when they cry, do they have tears?

Visual observation of elderly patients provides the physician with valuable information as well. It is important to see if the patient is able to ambulate on their own. Are they able to answer questions without assistance from a loved one?

When considering prenatal care visual observation is also extremely valuable. It would not be within the standard of care to make any decisions without being able to listen to the fetal heart tones.

The requirements established within this rule by our board help ensure that the standard of care is being met. In traditional medicine, physicians have been able to provide follow up care through a phone call. This has always been acceptable and still would be acceptable because the provider had already seen the patient in the office and then receive a phone call from them to discuss their care if something needed to be addressed. However, it has never been acceptable or within the standard of care to receive a cold call from an unknown patient who was referred to you and to diagnose and treat them based on a phone call or an email. This is exactly what we are attempting to avoid with this bill language.

With the introduction of what we now call telemedicine, we have an obligation to provide parameters that everyone understands to define a **new encounter** between a patient and a doctor who is unknown to them. To allow diagnosis and treatment to occur between a new patient and a new doctor based only on a telephone call and a questionnaire, leaves the public exposed to misdiagnosis due to a lack of proper evaluation. It also may contribute to the over prescription of antibiotics which is currently one of the CDC's major concerns.

The Board's ultimate goal is to ensure the standard of care is not altered based on the type of visit one would have.

I want to thank you for the opportunity to speak on behalf of the Board of Medicine and I am happy to answer any questions you may have.

Brenda Miller, MD
Board Member of the North Dakota Board of Medicine

SANFORD HEALTH

SB 2094 1/9/19 #4

Senate Human Services Committee
Sen. Judy Lee, Chair
Jan. 9, 2018

Chairman Lee and members of the Committee:

Sanford Health respectfully submits this letter in support of SB2094, the N.D. Board of Medicine's proposed telemedicine policy for the practice of medicine in North Dakota. We appreciate the opportunity to share our view on how this policy may affect the patients we serve across North Dakota.

For rural states like North Dakota where workforce is stretched thin and demand outpaces supply, telemedicine is emerging as a convenient, cost-effective alternative to traditional face-to-face consultations and examinations. Sanford Health increasingly employs telemedicine to improve access to services and reduce patients' costs associated with long-distance travel.

That said, Sanford strongly encourages you to pass SB2094. Sanford and other stakeholders have worked closely with NDBM to help craft language that balances ensuring high-quality care with leveraging technology to increase access. We appreciate NDBM's detailed, responsive approach to our comments.

One aspect of the rule discussed on multiple occasions is the requirement of a face-to-face visit—either in person or by video—to establish a new patent-provider relationship. We support this requirement as we believe certain aspects of quality care require a visual assessment, at times allowing the medical provider to identify important symptoms the patient or patient's parent may not self-report. In addition, we believe antibiotic stewardship—strategies to reduce unnecessary use of and prevent resistance to antibiotics—at times require visual assessment to accurately diagnose a problem that would benefit from antibiotic treatment.

Thank you for your consideration. If you need additional information, please contact either of us at your convenience.

Sincerely,

Chris Meeker, M.D.
Sanford Bismarck
Chief Medical Officer
Chris.Meeker@sanfordhealth.org
701-323-2601

Doug Griffin, M.D.
Sanford Fargo
Chief Medical Officer
Doug.Griffin@sanfordhealth.org
701-234-6160

SB 2094 1/9/19 #5 Pg. 1

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

Senate Human Services Committee
SB 2094
January 9, 2019

Chair Lee and Committee Members, I am Donna Thronson and represent the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students. NDMA supports SB 2094 for all the reasons stated by the Board of Medicine.

The physician-patient relationship is fundamental to the provision of acceptable medical care. Telemedicine actually has the power to enhance the physician-patient relationship. Requiring the face to face component is an essential part of that relationship.

It is generally accepted that a valid physician-patient relationship must exist before telemedicine services are provided. This relationship can be established in a few different ways:

•A face-to-face examination—an exam utilizing two-way, real-time audio and visual capabilities, like a videoconference—if a face-to-face encounter would be required for the same service in person
•A consultation with another physician who has an ongoing relationship with the patient
•Meeting evidence-based telemedicine practice guidelines developed by major medical specialty societies for establishing a patient-physician relationship

There are exceptions to these steps, such as emergency medical treatment, and on-call or cross coverage situations.

We would like to offer a friendly amendment. Mary Ann Sens, Professor and Chair of Pathology at the UND School of Medicine and Health Sciences, had contacted our office with a suggestion. Her testimony has been handed out along with NDMA's. We support this bill and support the amendment. However, we have discussed with the Board of Medicine and understand their concerns about it being an open-ended period of time. Therefore, we would suggest that on page 2, line 31, twenty-four hours be crossed out and insert 7 days.

Thank you for the opportunity to testify today. I would be happy to answer any questions.

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North Dakota Hospital Association Est. 1934

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: 2019 SB 2094
Senate Human Services Committee
Senator Judy Lee, Chairman
January 9, 2019

Good morning Chairman Lee and Members of the Senate Human Services Committee. I am Melissa Hauer, General Counsel of the North Dakota Hospital Association. I am here to testify regarding 2019 Senate Bill 2094 and ask that you give this bill a **Do Pass** recommendation.

The bill provides that a physician or physician assistant who wishes to practice telemedicine is required to have either an in-person or video-based visit as the first point of contact between that provider and a new patient. We agree that these methods are the appropriate ways in which to establish that valid patient/provider relationship. We also agree that an examination or evaluation consisting only of a static online questionnaire or an audio conversation does not appropriately meet this standard.

While telemedicine is an important new tool in healthcare and can bring many benefits to patients, we feel that patient safety is important too, especially when a provider is first treating a new patient. We feel this bill balances those competing interests appropriately.

In summary, we support the bill and ask that you give it a **Do Pass** recommendation. I would be happy to try to answer any questions you may have. Thank you.

Respectfully Submitted,
Melissa Hauer, General Counsel
North Dakota Hospital Association

PO Box 7340 Bismarck, ND 58507-7340 Phone 701 224-9732 Fax 701 224-9529

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Pg. 1

Honorable Senators of the Human Services Committee:

I am Dr. Mary Ann Sens, a pathologist working and teaching at the University of North Dakota School of Medicine and Health Sciences. I have resided in Grand Forks and held a ND medical license since 2002.

I wish to support an amendment to Senate Bill 2094. Along with the ND Board of Medicine and the ND Medical Association, I strongly support the concept and direction of this legislation and believe it protects North Dakota patients. However, one area needs clarification. Although the bill allows needed medical consultations, some consultations require more than the 24-hour period allowed. I present a simple amendment for your consideration. I believe this meets the spirit and intent of the bill while affording North Dakotans the best expert medical advice and consultation ability.

Proposed Amendment Section 2:

(5) An intra-specialty clinical consultation for diagnosis of a patient in this state, provided that both specialists are trained in the same specialty and the specialist requesting the consultation is a physician licensed to practice medicine in the state.

This is important in some areas of medicine, including pathology, but is also applicable to other complex consultations. It is common for pathologists to seek expert consultation on unusual or difficult cases; these consultations between pathologists involve sending slides, lab test results and/or other material to an expert who may be in any state (or country). Some tumors and other conditions are so rare or may require confirmatory testing done only in a few places; it is the standard of care within pathology to seek expert consultation for the best patient care and accurate diagnosis, including those out of state. These consultations usually require more than 24 hours. Thus, the current bill does not cover this existing pattern of medical care. It would not be feasible or desirable to have every pathologist in the country to have a medical license in ND; without this amendment, diagnostic excellence for North Dakota patients may be jeopardized. Although I speak from my own specialty because I am most familiar with it, other medical care instances and specialties would benefit from this amendment. Again, to speak from personal knowledge, one of my brothers is struggling with a very aggressive cancer. At a critical decision point in his treatment plan, his oncologist sent my brothers records, scans and pathology to another oncology expert in this particular cancer. Although this expert was out of state, she provided his local oncologist important treatment considerations. This review and tumor board meeting took five days. My brother received consultative care from a world specialist without leaving his local community; the actual treatment occurred within his home community. Note that both these examples of are local, licensed ND physicians reaching out to recognized experts who may not be in ND to get the best care options or diagnosis for a ND patient. This bill allows for this with the 24-hour teaching / consultative clause. However, some areas of medicine, such as pathology and some complex oncologic consultations may require more time. To serve ND residents and the integrity of the ND Board of Medicine, I urge you to adopt the proposed amendment, which would allow physicians in ND to consult with the best experts in their field without the constraint of 24 hours reflecting the medical reality that some consultations require more than 24-hours.

Respectfully,

Mary Ann Sens
5004 River Crest Rd
Grand Forks, ND 58201
masens@gmail.com

Horizon Virtual

January 10, 2019

Re: SENATE BILL NO. 2094

Senator Judy Lee – Chairman
Senator Oley Larsen – Vice Chairman
Senate Legislative Committee Members

North Dakota Senate Human Services Committee
North Dakota Senate – State Capitol
600 East Boulevard
Bismarck, ND 58505

Chairman Lee and Honorable Senator Committee Members:

I would like to again thank you for allowing me the opportunity and time on January 9th, to testify and comment on Senate Bill #2094 – relating to the practice of telemedicine. I would also like to send this letter of reference to reiterate my comments and hope for addendum to the bill as it is considered for action.

Briefly, I would like to refer to Section 5, on page 4 of the bill as it was introduced. At the end of the first paragraph (lines 18-21 on page 4) it reads: Opioids may only be prescribed through telemedicine if prescribed as a federal food and drug administration approved medication assisted treatment for opioid use disorder. Opioids may not be prescribed through a telemedicine encounter for any other purpose.

As an Internal Medicine Physician, working through a company that provides admission and consultative services via telemedicine to patients in Critical Access Rural Hospitals, this wording would unfortunately hinder my ability to care for these patients in the controlled hospital setting. We currently practice as privileged and credentialed Internal Medicine Board Certified staff physicians at these hospitals, and we write all orders needed to care for these hospitalized patients. We utilize advanced telemedicine equipment and trained nursing staff to help evaluate, diagnose and treat our patients just as we would with an in-person visit. After assessing and diagnosing the patient's condition, we write/enter orders into the hospital's electronic medical record for the care of the patient. There are times when the admission or consult diagnosis may require treatment with an opioid strength pain medication and we would need to prescribe this medication for the proper medical treatment of this patient. We believe that these patients, who are in a controlled medical treatment environment would be appropriate exceptions to controlled substance restrictions outlined in the proposed section of bill referenced above.

With this current workflow in mind, we would like to propose an amendment or addition for consideration to end of the paragraph in section 5, on page 4, line 18-21: ***With the exception of the hospitalized or skilled nursing facility patient,*** opioids may only be prescribed through telemedicine if prescribed as a federal food and drug administration approved medication assisted treatment for opioid use disorder. Opioids may not be prescribed through a telemedicine encounter for any other purpose.

Again, I thank you for your time and consideration. If you should have any further questions or concerns about this proposal or our current telemedicine practice, please do not hesitate to call or email.

Respectfully,

Darin Willardsen, MD, MBA, SFHM
CEO - Horizon Virtual
Internal Medicine Hospitalist
willardsend@horizonvirtual.net
Cell - (320) 492-0508
Office - (320) 345-5740

NDLA, S HMS - Velez, Justin

[redacted]om: Lee, Judy E.
Sent: Sunday, January 13, 2019 12:03 AM
To: NDLA, S HMS - Velez, Justin; NDLA, Intern 02 - Carthew, Alexandra
Subject: FW: Telemedicine Proposed Amendments

Copies for our books, please

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
home phone: 701-282-6512
e-mail: jlee@nd.gov

From: Bonnie Storbakken <BStorbakken@ndbom.org>
Sent: Friday, January 11, 2019 1:57 PM
To: Lee, Judy E. <jlee@nd.gov>; Larsen, Oley L. <olarsen@nd.gov>; Anderson, Jr., Howard C. <hcanderson@nd.gov>; Clemens, David <dclemens@nd.gov>; Hogan, Kathy L. <khogan@nd.gov>; Roers, Kristin <kroers@nd.gov>
Subject: Telemedicine Proposed Amendments

Hello Madam Chair and the members of the Senate Human Services Committee. I wanted to reach out to you all and let you know that our Board held a teleconference meeting this afternoon to discuss legislation. Within that discussion our Board reviewed the emails seeking amendment that were also discussed during the telemedicine hearing on Wednesday. There was a motion and a unanimous vote to support the proposed amendment in section five for hospitalized and nursing home patients. There was also a motion and unanimous vote to support the change in section three of the bill to change the one-time consultation or teaching assistance to a period of seven days rather than 24 hours. The Board felt both requests for amendment were reasonable.

Please do not hesitate to contact me directly with any questions you may have in this regard.
Sincerely,
Bonnie

Bonnie Storbakken
Executive Secretary
North Dakota Board of Medicine
418 East Broadway Ave.
Bismarck, ND 58501

(701)328-6500
Fax: (701)328-6505

Offered by Teladoc Health, Inc.

PROPOSED AMENDMENT TO SENATE BILL NO. 2094

Page 3, line 23, replace "A video" with "An"

Renumber Accordingly

SB 2094
1/14/19

#1 Pg 1

WESTLAW

West's Arkansas Code Annotated
Title 17. Professions, Occupations, and Businesses (Refs & Annos)
Subtitle 3. Medical Professions (Chapters 80 to 107) (Refs & Annos)
Chapter 80. General Provisions (Refs & Annos)
Subchapter4. Telemedicine Act

§ 17-80-403. Establishment of professional relationship

AR ST § 17-80-403 West's Arkansas Code Annotated Title 17. Professions, Occupations, and Businesses Effective: August 1, 2017 *(Approx. 2 pages)*

Effective: August 1, 2017

A.C.A. § 17-80-403

§ 17-80-403. Establishment of professional relationship

Currentness

(a)(1) A healthcare professional at a distant site shall not utilize telemedicine with respect to a patient located in Arkansas unless a professional relationship exists between the healthcare professional and the patient or the healthcare professional otherwise meets the requirements of a professional relationship as defined in § 17-80-402.

(2) The existence of a professional relationship is not required in the following circumstances:

(A) Emergency situations where the life or health of the patient is in danger or imminent danger; or

(B) Simply providing information of a generic nature, not meant to be specific to an individual patient.

(b) If the establishment of the professional relationship is permitted via telemedicine under § 17-80-402(4)(E) or § 17-80-402(4)(F), telemedicine may be used to establish the professional relationship only for situations in which the standard of care does not require an in-person encounter.

(c) "Professional relationship" does not include a relationship between a healthcare professional and a patient established only by the following:

(1) An internet questionnaire;

(2) An email message;

(3) Patient-generated medical history;

(4) Audio-only communication, including without limitation interactive audio;

(5) Text messaging;

(6) A facsimile machine; or

(7) Any combination thereof.

Credits

Acts of 2017, Act 203, § 2, eff. Aug. 1, 2017.

A.C.A. § 17-80-403, AR ST § 17-80-403

The constitution and statutes are current through (1) laws passed in the 2018 Fiscal Session and the Second Extraordinary Session of the 91st Arkansas General Assembly, (2) ballot issues adopted at the November 6, 2018, general election, and (3) changes made by the Arkansas Code Revision Commission received through October 31, 2018.

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#2 pg.1

NDLA, S HMS - Velez, Justin

From: Lee, Judy E.
Sent: Wednesday, January 09, 2019 1:11 PM
To: NDLA, S HMS - Velez, Justin
Subject: Fwd: FSMB Letter of Support - SB 2094

for committee records

Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
Phone: 701-282-6512
e-mail: jlee@nd.gov

Begin forwarded message:

From: "Anderson, Jr., Howard C." <hcanderson@nd.gov>
Date: January 9, 2019 at 12:54:20 PM CST
To: "Lee, Judy E." <jlee@nd.gov>, -Grp-NDLA Senate Human Services <ndlashumserv@nd.gov>
Subject: FW: FSMB Letter of Support - SB 2094

Information for the committee.

Howard C. Anderson Jr., R.Ph.
District 8 Senator
2701 7th St NW
Turtle Lake ND 58575-9667
Home 701-448-2235
Cell 701-861-9749
Senate 701-328-3373
E mail hcanderson@nd.gov
Committees: Human Services and Political Subdivisions
Real Work e mail: ndboph@ndboard.pharmacy

From: John Bremer <jbremer@fsmb.org>
Sent: Tuesday, January 8, 2019 2:44 PM
To: Anderson, Jr., Howard C. <hcanderson@nd.gov>
Subject: RE: FSMB Letter of Support - SB 2094

Senator Howard,

Thank you for your response. In regards to your question, there are at least 17 states with that specific provision included in their state telemedicine laws.

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Please let me know if you have any additional questions.

Regards,
John

John Bremer
Manager, State Legislation and Policy

Federation of State Medical Boards
1300 Connecticut Avenue, NW | Suite 500 | Washington, DC 20036
202-463-4021 direct | jbremer@fsmb.org | www.fsmb.org

From: Anderson, Jr., Howard C. <hcanderson@nd.gov>
Sent: Tuesday, January 8, 2019 2:53 PM
To: John Bremer <jbremer@fsmb.org>
Subject: RE: FSMB Letter of Support - SB 2094

Dear Mr. Bremer:

How many of the states that have used the model legislation have included this provision?

"Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient."

I have heard from some of the providers that this is too restrictive for them.

Thanks,

Howard

Howard C. Anderson Jr., R.Ph.
District 8 Senator
2701 7th St NW
Turtle Lake ND 58575-9667
Home 701-448-2235
Cell 701-861-9749
Senate 701-328-3373
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SB 2094
1/14/19
#2 pg. 3

From: John Bremer <jbremer@fsmb.org>
Sent: Tuesday, January 8, 2019 1:43 PM
Subject: FSMB Letter of Support - SB 2094

Dear Chairwoman Lee and Members of the Senate Human Services Committee –

On behalf of Humayun J. Chaudhry, DO, President and Chief Executive Officer of the Federation of State Medical Boards, please find attached a letter in support of Senate Bill 2094, which is before your Committee tomorrow, January 9.

Should you have any questions, please do not hesitate to let me know.

Best regards,
John

John Bremer
Manager, State Legislation and Policy

Federation of State Medical Boards
1300 Connecticut Avenue, NW | Suite 500 | Washington, DC 20036
202-463-4021 direct | jbremer@fsmb.org | www.fsmb.org

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FEDERATION OF
STATE MEDICAL BOARDS

January 8, 2019

Senator Judy Lee, Chairwoman
Human Services Committee
North Dakota Senate
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Chairwoman Lee and Members of the Committee,

On behalf of the Federation of State Medical Boards (FSMB), I would like to take this opportunity to comment on Senate Bill 2094. The FSMB urges the Committee to support this legislation.

The FSMB is a national, non-profit organization whose members include all of the 70 state medical and osteopathic licensing and disciplinary boards of the United States and its territories, including the North Dakota Board of Medicine. The FSMB's primary mission is to promote excellence in medical practice, licensure, and state-based regulation on behalf of its member medical boards as they strive to protect the public. The FSMB and its member boards are focused on improving the system of medical licensure in the U.S. and advancing the overall quality, safety, and integrity of health care.

As a membership organization, the FSMB serves as a conduit for member boards to share information and address current issues. The FSMB provides a variety of services to support state medical boards in carrying out their statutory responsibilities to protect the public. These services include developing model policies and identifying "best practices" for states, providing legal and policy research, and monitoring regulatory and legislative activity at the local, state and federal levels.

In 2014, the FSMB's House of Delegates unanimously approved the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.* This model policy, which has been adopted in part or in whole by a large number of states, provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients via telemedicine technologies.

Senate Bill 2094 follows several of the standards adopted in the FSMB's *Model Policy*, specifically in the following areas:

- The *Model Policy* defines telemedicine as, "the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare

provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient." Both Section 2 (§43-17-01 (5)) and Section 3 (§43-17-02.3(3)(a)) of SB 2094 meet the guidelines established within the *Model Policy*.

- The *Model Policy* states, "the [physician-patient] relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient." It continues to state that "a physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient." SB 2094, specifically Section 4 (§43-17-44(2)), adheres to FSMB's *Model Policy*.

- The *Model Policy* states, "prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person." Section 5 (§43-17-45) of SB 2094 meets the guidelines adopted within the *Model Policy*.

For the aforementioned reasons, the FSMB believes that Senate Bill 2094 will reduce regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public's health and safety.

Again, I thank you for the opportunity to comment on Senate Bill 2094 and urge you to support this legislation.

Sincerely,

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Pg. 1

Sanford Health Jamestown 2nd Avenue Clinic
300 2nd Avenue, NE
Jamestown, North Dakota 58401
January 11, 2019

The Honorable Judy Lee
Chair, Senate Committee on Human Services
North Dakota Capitol
600 East Boulevard Avenue
Bismarck, North Dakota 58505

Dear Senator Lee and Members of the Committee:

I am writing to you today to share some information as a local practicing physician regarding SB2094, relating to the practice of telemedicine. The legislation as drafted reflects some very good public policy regarding the practice of telemedicine, consistent with best practices from across the country with one notable exception that could unnecessarily restrict access to quality care in our state.

Before I give you details about what I consider to be some problematic language in SB2094 allow me tell you something about myself and my practice. I am a North Dakota native and graduate of the University of North Dakota for both undergraduate studies and the School of Medicine and Health Sciences. I am Board certified by the American Board of Family Medicine and have practiced family medicine, including women's health and pediatrics, for almost 12 years and serve as an assistant professor at the University of North Dakota School of Medicine. My practice today is at Sanford Health in Jamestown, but I also regularly treat patients using telemedicine. It is my experience with patients and telemedicine that is most relevant to your deliberations.

SB2094, among other details, appears to require a video examination of a patient in order to establish a valid physician- patient relationship through telemedicine. This requirement appears to be arbitrary as there are many non-emergent conditions presented by my patients every day for which a visual examination does not provide me with any more or special clinical information upon which I can base a diagnosis and prescribe treatment within the standard of care. It is best left to the discretion of the treating physician in every case whether or not the technology used is appropriate for the condition presented in order to meet the standard of care. By doing so you will afford every North Dakotan that can use a cell phone or landline the opportunity to access quality health care from a licensed North Dakota physician and not just those of us with access to reliable broadband technology, computers and smartphones. There is no patient safety or quality improvement gained by requiring an initial video visit. However, this requirement would notably decrease access to care and hurt healthcare equity in our state, especially in rural areas.

Thank you for this opportunity to comment on the legislation before your committee and your work to help increase access to quality, affordable health care to North Dakotans.

Respectfully,

Mandy Sorlie, MD

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Testimony for the North Dakota Human Services Committee

Dr. Donna Campbell, Member of Texas State Senate

Introduction

Good morning. My name is Donna Campbell. I am a board certified emergency room physician. I have served as the Emergency Department Medical Director for several hospitals. I have volunteered with Christian Eye Ministries and have performed hundreds of eye surgeries in the West African nation of Ghana. I am a member of the Texas State Senate. I am also a physician and subject matter expert for Teladoc Health and serve on the Teladoc Health National Quality Advisory Board.

Overview

I'm here today to speak to you as a practicing physician and to share with you facts that I know from my years of experience to be true; I spoke to you Administrative Rules Committee hearing in late 2017 on the very issue that we are discussing today. This initiative was proposed by Rule by the Board of Medicine. After much discussion, the Administrative Rules Committee opined against the Board because of concern that the proposed Rule would decrease access and diminish cost savings. What I see in SB 2094 is that same language that we talked about in the fall of 2017. Folks – nothing has changed since I was here last. There is a tremendous physician shortage nationwide and we can't build enough medical schools to address that; I believe that all Americans should have access to healthcare regardless of where they live, their computer literacy or their socioeconomic status – like Texas, North Dakota suffers from a lack of broadband in many areas of the state and from a physician shortage. I believe in the importance of a primary care physician relationship for all patients. However, I'm a realist and I know that a growing number of Americans don't have a PCP and that number is higher with our young people. I am convinced that removing barriers to the use of telemedicine will increase access and in turn will lead to better healthcare outcomes for your constituents in North Dakota who either don't have a PCP or when the PCP is not available. We must expect the best from all of our doctors therefore I support a standard of care that is based on what an average, reasonable physician would have done in a given situation. I hope that North Dakota will use evidence based information to develop good telemedicine policy.

In today's economy, individual resources are tight. Healthcare consumers want control as to how they spend their healthcare dollars. For many people who work an hourly wage job, taking an hour to drive to the doctor's office and then waiting to see the physician and going back to work can mean that the electricity bill doesn't get paid. Without access, these people show up in the ER with pink eye, the flu or some other non-emergent illness that utilizes the physician's time and hospital staff's time for something that could have been treated by telemedicine at the patient's home or at work – not to mention the cost that the patient and their employer will incur.

SB 2094 has an excellent definition of telemedicine and is technology neutral, which follows the Federation State Medical Boards – the is the national association that all state boards of medicine belong to- definition and I quote "Telemedicine Technologies means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider." The FSMB developed model policy that was not restrictive but hinged on the standard of care, knowing that technology moves much faster than the legislative and regulatory process. In fact, everything in the bill is quite good

until we get to Section 4 in which we again find the restrictive language put forward by the Board of Medicine several years ago. This language will place a huge barrier on access to healthcare using telemedicine in North Dakota and as a policy maker, I have to ask "why"?

Of all the concerns that I hear, the one that most disturbs me as a professional is that it's impossible to treat a patient over the phone and that a video interaction with the patient is required. We have been using the phone for years and I am quite comfortable with using a phone, if I have the patient's medical record in front of me. In the event that I don't feel that a telemedicine visit is appropriate, I will tell the patient that I either need to see something or the patient is expressing symptoms that need immediate attention. At all times, the physician has to meet the standard of care using their professional expertise. There is no data that shows that audio-video is a superior modality.

The North Dakota Board of Medicine has full oversight on any licensed physician; if a physician is not upholding the standard of care while using telemedicine, the Board has the absolute authority and duty to discipline that physician. Current law states that they physician must be licensed in the state where the patient is at the time of the encounter. This bill is placing restrictions on access to healthcare on those who need it most; as a policy maker I ask again…why? As a physician, I will repeat that there is no clinical evidence that supports video as a superior technology as long as the physician has access to and reviews the patient's medical history.

Conclusion

As legislators, we want to know what is the ask and what can we do to make legislation or regulations better. In this case, I ask that you remove the requirement that an audio-visual consultation must be done at the first interaction. There is absolutely nothing to be gained by the requirement and much to be lost. It will create a barrier for those who stand to gain the most from telemedicine – those who live in rural areas. I would suggest that you ask where the clinical data is that supports this rule. I will submit to you that there is none. Thank you for your time and your interest in telemedicine. As policy makers we want to know that what we do benefits our citizens and that we put safety first; that we improve access to quality healthcare and that we do not erect unnecessary barriers that increase costs to our employers and restrict their ability to use every tool available to keep a healthy workforce so that they can compete nationally. I know that we are limited in time and there's a lot more that I could say but will be glad to answer any questions.

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Teladoc HEALTH

Good afternoon Chairwoman Lee and members of the Committee,

My name is Claudia Tucker and I am the Vice President of Government Affairs for Teladoc Health. In this capacity I have oversight of all state legislative and regulatory affairs as well as for all work at the federal level. In this capacity I have a unique view of what is going on nationally relative to telemedicine policy and how the states are addressing it. As we all know, each state likes to put their mark on policy that effects their citizens and telemedicine policy is no different. I have been engaged in health care policy for a number of years and we all know that there is no silver bullet for savings or access. However, I will tell you that telemedicine has the ability to move the needle in a significant manner for both access to care and cost savings. Having said that, policy that may be well intended could have unforeseen consequences that can rob your citizens of access and completely diminish the cost savings. This bill as drafted will have that chilling effect.

Teladoc is the world's largest telemedicine company delivering on-demand healthcare anytime via mobile devices, a web-based portal, video and interactive audio. We connect our members with a staff of over three hunded doctors and a network of over 3100 board certified physicians with an average of over 15 years of experience. In 2018 Teladoc Health completed over 2.5 million virtual visits and we have over 24 million members worldwide. Telemedicine is dynamic and evolving and we appreciate the role that the Legislature and Board of Medicine have in considering an approach that is protective of public health and maintaining high quality care for patients while being permissive of innovation that allows for expanded telemedicine services in the state. With over 100 proprietary clinical guidelines, NCQA and HIRUST certification, nothing is more important to Teladoc Health than quality health care.

You've heard from Senator Campbell and before you is a letter from Dr. Mandy Sorlie who practices over in Jamestown. In addition to being a very busy physician, and an associate professor at the University of South Dakota, she is also a Teladoc physician. As you've heard from Senator Campbell and from one of your own physicians, there is absolutely no clinical argument to require a video first examination for a variety of non-emergent illnesses. If the standard of care requires the physician see something during the telemedicine consult, the physician has the ability and the responsibility to tell the patient that the visit must have a video component. Let me be clear; while I am here on behalf of Teladoc this is not a "Teladoc" concern, this is an industry concern. Teladoc does both video and interactive audio, so for us it really is patient choice and physician discretion. I am here today because our clients and their employees

have asked that we do everything possible to protect this important benefit that allows access to quality care. There is no good reason why the citizens of North Dakota should be disenfranchised from quality healthcare just because they don't have broadband or a smart phone or a computer. It would be nice if all Americans had what most of us take for granted but they don't. Over 62 million Americans don't have access to a primary care provider; eighty percent of ER visits are due to a lack of access to a primary care provider. Telemedicine is a tool that will address the access to care issue, along with providing the citizens and businesses of North Dakota a way to keep healthcare affordable.

I will leave you with three things and then will be glad to answer any questions. First, there are only two other states who have enacted legislation similar to what ND is contemplating; those are Arkansas and Delaware and we expect that both will have legislation pending to address that defect in the upcoming session. Second, in North Dakota in 2018, Teladoc Health completed over 1500 virtual visits and saved the companies and employees of the state over $700kin healthcare costs. Lastly, our clients in North Dakota include companies such as Cargill, Halliburton, Marathon Petroleum, NTCA Rural Broadband and Tractor Supply and they support an approach that allows for the maximum benefit for telemedicine. I respectfully ask that you support the amendment which keeps the positive aspects of this bill and includes language that will allow for access to care and cost savings for all. Thank you.

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Monday, January 14, 2019

Senate Human Services Committee
SB 2094

SEN. LEE AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing on behalf of America's Health Insurance Plans or, as it is commonly known, AHIP. AHIP is the national trade association representing the health insurance industry.

AHIP members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual and small group insurance markets, and public programs such as Medicare and Medicaid.

As an industry, we are supportive of efforts to improve access to quality care. As technology has evolved in recent years, telemedicine has become an option for achieving this goal by removing traditional barriers to health care delivery such as distance, mobility, and time constraints.

Today, we would like to raise a concern that we have regarding subsection 3 of Section 4, line 19, page 3, that we raised when this was considered by the interim Administrative Rules Committee, which requires that before initially diagnosing or treating a patient for a specific illness or condition, an examination must be performed. While that examination or evaluation may be performed using telemedicine, it must equivalent to an in-person examination.

This requirement would place a significant delay and operational constraint on a significant number of medical services. We believe that patients, providers, and health plans should have choice and flexibility regarding the use of telemedicine services. Mandating that an initial examination be performed, and that it be equivalent to an in-person examination, becomes an artificial barrier to care.

This standard also fails to consider the evolving nature of telemedicine technology, and it limits a patient's options when deciding on the best course of action to obtain health care. There are circumstances where telemedicine services provided via audio-only consultations are appropriate. Patients, their providers, and health plans are best positioned to make these types of determinations and need to have the flexibility to do so.

To that end, we respectfully request that Section 4, subsection 3 be removed in its entirety.

Thank you for your time and consideration. If you have any questions I would be glad to try to answer them.

NORTH DAKOTA PSYCHIATRIC SOCIETY

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A District Branch of the
American Psychiatric Association

Jan 14, 2019
From: ND Psychiatric Society
Letter of Support for SB 2094

Madam Chairwoman, esteemed members of the assembly,

On behalf of the ND Psychiatric Society, we are writing in support of SB 2094, which we believe upholds the telemedicine principles promoted by our professional organization, the APA[1].

We salute the specifications related to the **controlled substances prescribing**, which will help keep our patients safe.

We fully agree with the clarification of what constitutes a **patient-licensee relationship**, which, time and again, has been proven to be the **single most important** factor contributing to a treatment's positive outcome[2]. The relationship can only take place in a "**holding environment**", where the patient feels safe enough to reveal his/her vulnerabilities and work on change[3]. Revealing troubling thoughts, feelings, and behaviors is the only way to heal those. The therapist/licensee's role is to contain those and help the patient process them. This process requires **building trust** in the therapist/licensee. I wonder how one builds trust with a questionnaire?

One may say that diagnosing a psychiatric disorder will lead to "medication management" treatment and good outcomes. In fact, robotically administering pills based on an algorithm will not change maladaptive behaviors, thus relapse and suffering will recur. We spend a fifth of our GDP on healthcare, (out of which 12% on prescription drugs), yet it contributes to our health by 10%, whereas **changing behaviors** contributes with more than 40% [4].

In sum, we have a solid body of literature that proves that initial encounters via videoconferencing elicit good quality therapeutic relationships[5]. Until we have the same type of evidence for questionnaire-based initial encounters, we as a professional society cannot sanction this type of practice.

We thank the Human Service Committee for providing us with a well-written bill and we thank you for listening,

Balf-Soran

Gabriela Balf-Soran, MD, MPH
ND Psychiatric Society President
APA State Representative
Associate Director – UND School of Medicine – Behavioral Sciences and Psychiatry Dept

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1. Shore J. et al., *Best Practices in Videoconferencing-Based Telemental Health April 2018.* Telemedicine and e-Health, 2018. **24**(11): p. 827-832.
2. Pan, A.-W. and L.-T. Liu, *Therapeutic Relationship and Treatment Outcome.* American Journal of Occupational Therapy, 2016. **70**(4_Supplement_1): p. 7011510234p1-7011510234p1.
3. Fletcher, K.L., S.D. Comer, and A. Dunlap, *Getting Connected: The Virtual Holding Environment.* Psychoanalytic Social Work, 2014. **21**(1-2): p. 90-106.
4. Braveman, P. and L. Gottlieb, *The social determinants of health: it's time to consider the causes of the causes.* Public health reports (Washington, D.C. : 1974), 2014. **129 Suppl 2**(Suppl 2): p. 19-31.
5. Richard O'Reilly , M.B., F.R.C.P.C. ,, et al., *Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results From a Randomized Controlled Equivalence Trial.* Psychiatric Services, 2007. **58**(6): p. 836-843.

SB 2094 – Proposed Amendment

43-17-45. Prescribing – Controlled substances.

1. A licensee who has performed a telemedicine examination or evaluation meeting the requirements of this chapter may prescribe medications according to the licensee's professional discretion and judgment. Opioids may only be prescribed through telemedicine if prescribed as a federal food and drug administration approved medication assisted treatment for opioid use disorder. Opioids may not be prescribed through a telemedicine encounter for any other purpose, with the exception of patients in a hospital or long-term care facility.

Offered by Teladoc Health, Inc.

PROPOSED AMENDMENT TO SENATE BILL NO. 2094

Page 3, line 23, after "a." insert "(1)"

Page 3, line 29, replace "." with ", or"

Page 3, line 30, before "b." insert the following:
"(2) An examination using asynchronous store and forward technology, including asynchronous store and forward technology in conjunction with sychronous audio interaction between the practitioner and the patient in another location meets this standard, as long as the practitioner uses clinical information from: (a) clinically relevant photographic or video images, including diagonostic images; or (b) the patient's relevant medical records, such as the relevant medical history, laboratory and pathology results, and prescritive histories."

Renumber Accordingly

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Testimony of Bonnie Storbakken, Executive Secretary of the North Dakota Board of Medicine in support of Engrossed SB 2094 with proposed Amendments

Good morning Chair, Representative Weisz and members of the House Human Services Committee. My name is Bonnie Storbakken. I am the Executive Secretary for the North Dakota Board of Medicine.

I am here on behalf of the Board of Medicine to introduce Engrossed SB 2094 to you. This Bill attempts to provide parameters for our licensees regarding the practice of telemedicine and provide the structure necessary to fulfill the mission of the Board to protect the public through the regulation of the Practice of Medicine.

First, I would like to provide some historical context. Second, I will walk through each section of the Bill. And third I will talk about some examples our Board has seen causing the Board to begin the process of putting these parameters in place. Fourth, I will address the other places in law this body has addressed telemedicine. Fifth, I will discuss model policy proposed by the American Medical Association, (AMA) and Federation of State Medical Boards, (FSMB) and tell you what other states are currently doing. And lastly, I will discuss some of the opposition.

Historical Context: The Bill you see before you is the result of much work on the part of the North Dakota Board of Medicine. Initially, the Board of Medicine sought to regulate telemedicine through the Administrative Rules Process. The result of the Administrative Rules process left much of the language out of our rule. The Administrative Rules Committee directed the Board to address this matter with the legislature rather than through the rule making process. The Board felt that it was important to seek language that provides guidance and direction to our licensees regarding telemedicine. In this vain that Board submitted an agency bill that mirrored the language previously sought in rule.

(Attachment 1, Current Rule) (The packets submitted to the Administrative Rules Committee in December 2017 and March 2018 with the pertinent portion of the minutes attached to each packet have been provided separately as Historical documents)

It is no secret that the language proposed by the Board was met with opposition in the rule making process and within the legislative process as well. I can assure you that it is not the intent of the Board to be overly burdensome or restrictive. Rather it is the intent to prevent harm and provide parameters to guide practice.

The Senate Human Services Committee heard our original Bill on January 9, 2017 as well as on January 14, 2019. The Senate Human Services Committee approved three amendments to the bill. One amendment in section two which provides additional time to our 24-hour consultation. An amendment in section three which added language to the type of examination that would be required for the establishment of the patient-licensee relationship through telemedicine. The final amendment is in section four which added language allowing

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opioids to be prescribed through telemedicine to a patient in a hospital or long-term care setting. I will address the specific amendments as I discuss each section of the bill.

SB 2094:

SECTION 1

Section one of the bill provides definitions for "Licensee" and for "Telemedicine".

SECTION 2

Section two of the bill provides that practice is deemed to occur where the patient is and that a licensee providing care to a patient located in ND must be licensed in ND. An amendment was made to this section by the Senate Human Services Committee. On page two line 24, "twenty-four hours", was stricken and replaced by, "seven days". Our Board had no objection to this proposed amendment. This amendment came from a member of the North Dakota Medical Association and was supported by our Board. It is my understanding that there is a desire to strike the words "one-time" on line 23 as well which our board would not object to.

SECTION 3

Section three of the Bill is the source of much of the opposition that was seen within the rules process. This section is intended to ensure that all practice done through telemedicine is held to the same standard of care as traditional or in person medical care.

Subsection one, beginning on page 3 line five speaks to the scope of practice and states that licensees provide care within their scope of education, training and expertise.

Subsection two beginning on page three line 10 states that a patient-licensee relationship must be established prior to the diagnosis and treatment of a patient. This subsection also states the licensee must verify the identity of the patient and disclose their identity to the patient.

Subsection three beginning on page three line 15 is intended to provide clarity on how to establish a patient-licensee relationship through the use of telemedicine if one does not already exist. The language in subsection 3a beginning on page three line 19 was amended by the Senate Human Services Committee to allow the establishment of a patient licensee relationship using store-and-forward technology in addition to a videoconference or the utilization of an intervening health care provider. This allows a doctor who has never met or seen a patient to utilize medical records and patient provided information to establish the required patient-licensee relationship. The Board of Medicine was not in favor of this amendment and is seeking an amendment that would restore the Boards original intent.

Our Board believes that if the relationship is being established through the use of telemedicine the initial examination must be done with the use of video and or an appropriately licensed intervening health care provider. As such, our Board would seek to strike the words, "or store-and-forward technology", which begins on page three line 19 and continues onto line 20. It

was important for the Board to be clear that the use of audio conversation or an online static questionnaire would not be an acceptable means to establish the patient-licensee relationship. Once a relationship is established the use of telemedicine to provide care would be at the discretion of the licensee. This subsection also attempts to carve out exceptions to the patient-licensee relationship requirement for certain types of telemedicine such as teleradiology and ICU monitoring.

Subsection four beginning on page four line four is intended to provide clarity that medical records must be maintained under our current laws regardless of the delivery of the care. Subsection five beginning on page four line seven is intended to ensure that proper referrals will be made if the patient is not amenable to diagnosis through telemedicine.

SECTION 4

Section four of the bill is intended to ensure that any and all prescribing done through telemedicine must adhere to all state and Federal Laws including the rules regarding the Prescription Drug Monitoring Program, (PDMP) reporting requirements. This section also provides parameters for opioid prescribing. The opioid prescribing section was amended in the Administrative rules process to allow an exception to the ban on opioid prescribing for MAT purposes. The reasoning for prohibiting the prescription of opioids was in response to the opioid prescribing issues seen across the nation. This language was further amended in the Senate Human Services Committee to allow prescribing of opioids for patients in a hospital or long-term care facility. This amendment was one that was brought forward by some practicing physicians who provide services in hospital and long-term care settings. Our Board had no objection to this amendment.

Examples of Concern:

A patient complaint that the "physician" they were consulting with would not disclose their identity.

Patients that received cold calls asking questions about their medication and then received unsolicited prescription medications in the mail.

Complaint that unnecessary testing was being done through a telemedicine practice for purposes of improper billing.

These are just a few examples that are concerning to the Board of Medicine. If a relationship exists between a licensee and a patient these incidents are decreased, and tools are provided in a clear way for the Board to address the issue.

Other ND Laws that Mention Telemedicine:

NDCC 26.1-36-09.15 Coverage of telehealth services: this statute defines telehealth and provides the parameters for payment of telehealth services. It should be noted that this

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statute also states that telehealth does not include audio only telephone, electronic mail, or facsimile transmissions.

(Attachment 2: NDCC 26.1-36-09.15)

N.D.C.C. 19-24.1-01(3) provides a definition of provider-patient relationship:

"Bona fide provider-patient relationship" means a treatment or counseling relationship between a health care provider and patient in which all the following are present: The summary of the requirements listed are a review of the patient's medical records and current medical condition including an in person medical evaluation of the patient and a requirement to maintain records.

(Attachment 3 NDCC 19-24.1-01(3))

AMA and FSMB Model Policy:

I have attached model language drafted by the AMA regarding telemedicine. You can see from the language that our Bill is in line with what the AMA has proposed as good policy for telemedicine. Both our Bill and the AMA proposed language require licensure in the state where the patient is located. Both require that prior to treating a patient via telemedicine there must first be a physician-patient relationship. The AMA language includes verifying the identity of the patient and physician. The AMA language sets out requirements for consents, diagnosing, follow up care and medical records.

(Attachment 4 AMA Model language)

The FSMB model policy is less prescriptive in its approach to providing policy guidance but it also touches on the same areas and requirements of establishing a relationship, ensuring the ability to confirm the identity of both the patient and physician, referrals, medical records.

The overall approach set out by the model language as well as the Boards bill aim to affirm that the standard of care is maintained regardless of the delivery method of the medical care. I have attached the FSMB Model Language as well as a letter addressed to the Senate Human Services Committee from the President of the FSMB in support of this SB 2094.

(Attachment 5 FSMB Model Language)

Criticism of the Rule:

The requirement of video is overly burdensome due to a lack of broadband availability to many rural patients. I have attached a ND broadband report which states that North Dakota has some of the best broadband coverage in the nation. I have also attached a recent article published in the Grand Forks Herald which discusses North Dakota's Broadband in relation to the National picture. Also, let's consider that it was not that long ago that all patients had to travel to a physician to be treated every time they required treatment. A onetime video and or

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in person visit to establish care is still an advancement from an in person visit every time one needs care.

(Attachment 6 Broadband Article and Report)

The comments received during the Administrative Rules process can be found within attachment the historical documents. I would like to point out that our Board has taken public comments during two open comment periods which included scheduled hearings for public. Additionally, our Board reviewed and discussed comments made after the comment period during the Administrative Rules hearing process. Our Board feels strongly even after listening to and discussing all comments that the Patient- Licensee relationship language is necessary to provide the parameters needed to its licensees and to provide the framework from which to review complaints received relating to telemedicine.

At the Boards November 2018 meeting I was directed to submit an agency bill for telemedicine using the language that was used in the rule making process. Once the language was complete it was sent out in a blast email to all our licensees. I have attached the feedback I received from that blast email.

(Attachment 7 recent emails from licensees)

Bonnie Storbakken
Executive Secretary, NDBOM
701-328-6500
bstorbakken@ndbom.org

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ATTACHMENT 1

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NORTH DAKOTA
Board of Medicine

Telemedicine Rule Effective 1-1-18

CHAPTER 50-02-15

TELEMEDICINE

50-02-15-01. Definitions. As used in this chapter:

1. "Telemedicine" means the practice of medicine using electronic communication, information technologies, or other means between a licensee in one location and a patient in another location, with or without an intervening health care provider. The term includes direct interactive patient encounters as well as asynchronous store-and-forward technologies and remote monitoring.

2. "Licensee" means a physician or physician assistant licensed to practice in North Dakota. A physician assistant practicing telemedicine from another state is subject to the rules regarding physician supervision, except that supervision may be by a North Dakota licensed physician who is practicing telemedicine in North Dakota and need not be by a North Dakota licensed physician who is physically located in North Dakota.

50-02-15-02. Prescribing.

A licensee who has performed a telemedicine examination or evaluation meeting the requirements of this chapter may prescribe medications according to the licensee's professional discretion and judgment. Opioids may only be prescribed through telemedicine if done so as a federal Food and Drug Administration approved medication assisted treatment for opioid use disorder. Opioids may not be prescribed through a telemedicine encounter for any other purpose.

Licensees who prescribe controlled substances, as defined by North Dakota law, in circumstances allowed under this rule, shall comply with all state and federal laws regarding the prescribing of controlled substances, and shall participate in the North Dakota prescription drug monitoring program.

more news

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ATTACHMENT 2

26.1-36-09.11. Breast reconstruction surgery.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, or franchise basis unless the policy, contract, or evidence of insurance provides the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998 [Pub. L. 105-277; 112 Stat. 2681-337; 42 U.S.C. 300gg-6]. This section does not apply to individual or group supplemental, specified disease, long-term care, or other limited benefit policies.

26.1-36-09.12. Medical services related to suicide.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any hospital, surgical, medical, or major medical benefit policy on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any individual covered under the policy or contract for injury or illness resulting from suicide, attempted suicide, or self-inflicted injury. The medical benefits provided for in this section are exempt from section 54-03-28.

26.1-36-09.13. Medical services related to intoxication.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any major medical expense policy on a group, individual, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any individual covered under the policy or contract for injury or illness resulting from any loss sustained or contracted in the consequence of the insured's being intoxicated or under the influence of any narcotic. The coverage required under this section may be subject to limitations under subdivision g of subsection 2 of section 26.1-36-04 or subsection 15 of section 26.1-36-05.

26.1-36-09.14. Coverage of cancer treatment medications.

1. As used in this section:
   a. "Cancer treatment medications" means prescription drugs and biologics that are used to kill, slow, or prevent the growth of cancerous cells.
   b. "Insurer" means an insurance company, nonprofit health service corporation, or health maintenance organization.
   c. "Patient-administered" includes oral administration and self-injection.
   d. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.
2. An insurer may not deliver, issue, execute, or renew a policy that provides coverage for cancer treatment medications that are injected or are intravenously administered by a health care provider and that provides coverage for patient-administered cancer treatment medications unless the policy copayment, deductible, and coinsurance amounts for patient-administered cancer treatment medications do not exceed the amounts for cancer treatment medications that are injected or are intravenously administered by a health care provider, regardless of the formulation or benefit category.
3. An insurer may not increase a copayment, deductible, or coinsurance amount for covered cancer treatment medications that are injected or intravenously administered in order to avoid compliance with subsection 2. An insurer may not reclassify benefits with respect to cancer treatment medications in a manner that is inconsistent with this section.

26.1-36-09.15. Coverage of telehealth services.

1. As used in this section:

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a. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.
b. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.
c. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.
d. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.
e. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.
f. "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.
g. "Telehealth":
   (1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.
   (2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.
   (3) Does not include the use of audio-only telephone, electronic mail, or facsimile transmissions.

2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.
3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner as the insurer with the health services providers in the same manner as the insurer establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.
4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.
5. This section does not require:
   a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;
   b. A policy to provide coverage for health services delivered by means of telehealth if the policy would not provide coverage for the health services if delivered by in-person means;
   c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or
   d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

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ATTACHMENT 3

40. "Written certification" means a form established by the department which is executed, dated, and signed by a health care provider within ninety calendar days of the date of application, stating that in the health care provider's professional opinion the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition. A health care provider may authorize the use of dried leaves or flowers of the plant of the genus cannabis in a combustible delivery form to treat or alleviate the patient's debilitating medical condition. A written certification may not be made except in the course of a bona fide provider-patient relationship.

19-24.1-02. Medical marijuana program.

The department shall establish and implement a medical marijuana program under this chapter to allow for production and processing, the sale and dispensing of usable marijuana, and medical use of marijuana. A person may not produce or process or sell, possess, transport, dispense, or use marijuana or usable marijuana under the medical marijuana program unless the person is authorized to do so as a compassion center, a cardholder, or otherwise authorized by rule adopted under this chapter.

19-24.1-03. Qualifying patients - Registration.

1. A qualifying patient is not eligible to purchase, use, or possess usable marijuana under the medical marijuana program unless the qualifying patient has a valid registry identification card.
2. A qualifying patient application for a registry identification card is complete and eligible for review if an applicant submits to the department:
   a. A nonrefundable annual application fee in the amount of fifty dollars, with a personal check or cashier's check payable to "North Dakota State Department of Health, Medical Marijuana Program".
   b. An original written certification, which must include:
      (1) The name, address, and telephone number of the practice location of the applicant's health care provider;
      (2) The health care provider's North Dakota license number;
      (3) The health care provider's medical or nursing specialty;
      (4) The applicant's name and date of birth;
      (5) The applicant's debilitating medical condition and the medical justification for the health care provider's certification of the patient's debilitating medical condition;
      (6) Attestation the written certification is made in the course of a bona fide provider-patient relationship and that in the provider's professional opinion the applicant is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the applicant's debilitating medical condition;
      (7) Whether the health care provider authorizes the patient to use the dried leaves or flowers of the plant of the genus cannabis in a combustible delivery form; and
      (8) The health care provider's signature and the date.
   c. An original qualifying patient application for a registry identification card form established by the department which must include all of the following:
      (1) The applicant's name, address, and date of birth.
      (2) The applicant's social security number.
      (3) The name, address, and date of birth of the applicant's proposed designated caregiver, if any.
      (4) A photographic copy of the applicant's North Dakota identification. The North Dakota identification must be available for inspection and verification upon request of the department. If the applicant is a minor, a certificated copy of a birth record is required.

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(5) The applicant's or guardian's signature and the date, or in the case of a minor, the signature of the minor's parent or legal guardian with responsibility for health care decisions and the date.

d. A signed consent for release of medical information related to the applicant's debilitating medical condition, on a form provided by the department.

e. A recent two-by-two inch [5.08-by-5.08 centimeter] photograph of the applicant.

f. Any other information or material required by rule adopted under this chapter.

3. If the applicant is unable to submit the required application information due to age or medical condition, the individual responsible for making medical decisions for the applicant may submit the application on behalf of the applicant. The individual responsible for making medical decisions:

a. Must be identified on the qualifying patient application for a registry identification card; and

b. Shall provide a copy of the individual's North Dakota identification. The North Dakota identification must be available for inspection and verification upon the request of the department.

4. If the applicant is a minor, the department may waive the application or renewal fee if:

a. The parent or legal guardian of the applicant is the applicant's registered designated caregiver; and

b. The applicant resides with the applicant's registered designated caregiver.

19-24.1-04. Designated caregivers - Registration.

1. A designated caregiver is not eligible to purchase, assist in the use of, or possess usable marijuana under the medical marijuana program unless the designated caregiver has a valid registry identification card.

2. A designated caregiver application is complete and eligible for review if an applicant submits to the department all of the following:

a. A nonrefundable annual application fee in the amount of fifty dollars, with a personal check or cashier's check made payable to "North Dakota State Department of Health, Medical Marijuana Program".

b. An original designated caregiver application for a registry identification card form established by the department which must include all of the following:

(1) A certified copy of a birth record verifying the applicant is at least twenty-one years of age.

(2) A photographic copy of the applicant's North Dakota identification. The North Dakota identification must be available for inspection and verification upon request of the department.

(3) The name, address, telephone number, and date of birth of the qualifying patient.

(4) The name, address, and telephone number for the qualifying patient's health care provider.

(5) The name, address, and telephone number of the applicant.

(6) The applicant's social security number.

(7) The applicant's signature and the date.

c. An original designated caregiver authorization form established by the department which must be executed by a registered qualifying patient providing the designated caregiver applicant with the responsibility of managing the well-being of the registered qualifying patient with respect to the registered qualifying patient's medical use of marijuana. The form must include:

(1) The name and date of birth of the designated caregiver applicant; and

(2) The registered qualifying patient's signature and the date.

d. A recent two-by-two inch [5.08-by-5.08 centimeter] photograph of the applicant.

e. Any other information or material required by the department by rule.

3. A criminal history record check conducted under section 12-60-24 must be performed upon initial application and biennially thereafter and at any other time upon the request

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AMA AMERICAN MEDICAL ASSOCIATION

IN THE GENERAL ASSEMBLY STATE OF _____

Telemedicine Act

Be it enacted by the People of the State of _____, represented in the General Assembly:

Section 1. Title. This act shall be known as and may be cited as the Telemedicine Act.

Section 2. Definitions.

(A) "Telemedicine" or "telehealth" means health care services provided to a patient who is at a remote location.

(B) "Store and forward" transfer means the transmission of a patient's medical information from an originating site to the physician at the distant site without the patient being present.

(C) "Distant site" means a site at which a physician is located while providing health care services by means of telemedicine.

(D) "Originating site" means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine.

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Section 3. Licensure.

(A) Physicians treating patients in [State] through telemedicine or telehealth must be fully licensed to practice medicine in [State] and shall be subject to regulation by the [State] Board of Medicine.

(B) This section does not apply to:

(1) An informal consultation or second opinion, at the request of a physician licensed to practice medicine in this state, provided that the physician requesting the opinion retains authority and responsibility for the patient's care; and

(2) Furnishing of medical assistance by a physician in case of an emergency or disaster if no charge is made for the medical assistance.

***Drafting Note**—to provide further guidance on exceptions to telemedicine licensure, this drafting note provides a representative sample from states with telemedicine licensure laws.*

(3) Consultation services provided by a physician located in another jurisdiction to a medical school as defined in [Statute] or an institution defined in [Statute governing other schools of health (e.g. dental school, school of public health, school of nursing)]; and

(4) Ordering home health or hospice services for a resident of this state to be delivered by a home and community support services agency licensed by this state, by the resident's treating physician who is located in another jurisdiction of a state having borders contiguous with the borders of this state.

(C) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting or in a manner not otherwise authorized by the laws of this state.

Section 4. Evaluation and Treatment of the Patient.

(A) Telemedicine shall not be utilized by a physician with respect to any patient located in [State] in the absence of a physician-patient relationship.

(B) Physicians who utilize telemedicine shall, if such action would otherwise be required in the provision of the same service not delivered via telemedicine, ensure that a proper physician-patient relationship is established which at a minimum includes:

(1) (a) an appropriate face-to-face examination prior to diagnosis and treatment of the patient, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or

(b) a consultation with another physician who has an ongoing relationship with the patient, provided that the physician requesting the consultation retains authority and responsibility for the patient's care;

(2) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient;

(3) disclosing and validating the physician's identity and applicable credential(s);

(4) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including informed consents regarding the use of telemedicine technologies as indicated in Section 5;

(5) establishing a diagnosis through the use of acceptable medical practices, including patient history, mental status examination, physical examination (unless not warranted by the patient's mental condition), and appropriate diagnostic and laboratory testing to establish diagnoses, as well as identify underlying conditions or contra-indications, or both, to treatment recommended or provided;

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(6) discussing with the patient the diagnosis and the evidence for it, the risks and benefits of various treatment options;

(7) ensuring the availability of appropriate follow-up care; and

(8) providing a visit summary to the patient.

(C) The requirements of Section 4(B) do not apply to:

(a) emergency situations in which there is an occurrence that poses an imminent threat of a life-threatening condition or severe bodily harm.

(b) treatment provided in an on-call or cross-coverage situation. An "on-call" physician is a [State] licensed physician who is available to physically attend, if necessary, to urgent and follow up care needs of a patient for whom he or she has temporarily assumed responsibility as designated by the patient's treating physician. A "covering" physician means a physician who conducts a medical evaluation other than an in-person medical evaluation at the request of a physician who has conducted at least one (1) in-person medical evaluation of the patient within the previous twelve (12) months and who is temporarily unavailable to conduct the evaluation of the patient.

(D) Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of care as those in traditional (encounter in person) settings.

***Drafting Note re: Medical Home**—States may wish to include language recommending that, if a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.*

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Drafting Note re: Online Prescribing—*To provide further guidance on provisions addressing prescribing in response to online or telephone questionnaires, states may wish to include the following language:*

(E) Without a prior and proper physician-patient relationship, physicians are prohibited from issuing prescriptions solely in response to an Internet questionnaire, email message, or audio-only telephone consult.

Drafting Note re: Exceptions—*States may wish to address the application of this section to specialty practice such as radiology, neurology, pathology, dermatology and others, as appropriate, where the application of technology in medical practice is well established, defined and constitutes the standard of care.*

Section 5. Coverage of telemedicine services.

(A) Each carrier offering a health plan in this state shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

(B) A carrier offering a health plan in this state shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a physician and a patient for services appropriately provided through telemedicine services.

(C) A carrier offering a health plan in this state shall not be required to reimburse the treating physician or the consulting physician for technical fees or costs for the provision of telemedicine services; however, such carrier shall reimburse the treating physician or the consulting physician for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the carrier is responsible for coverage for the provision of the same service through in-person consultation or contact.

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(D) A carrier offering a health plan in this state may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through in-person diagnosis, consultation, or treatment.

(E) No carrier offering a health plan in this state shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(F) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in [State] on and after January 1, 20__, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(G) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

Drafting Note re: Utilization Review and Prior Authorization*—States may wish to include the following provision regarding utilization review and prior authorization:*

(H) Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services,

provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan, and provided all adverse determinations are made by a physician who possesses a current and valid non-restricted license to practice medicine in [State] and is board certified or eligible in the same specialty as the physician who typically manages the medical condition or disease or provides the health care service. Any such utilization review shall not require prior authorization of emergent telemedicine services.

Section 6. Informed Consent.

(A) The physician must follow applicable state and federal statutes and regulations for informed consent.

Section 7. Privacy Practices.

(A) The physician must follow applicable state and federal statutes and regulations for privacy and security of individually identifiable health information.

Section 8. Medical Records.

(A) The physician treating a patient through telemedicine must maintain a complete record of the patient's care.

(B) The physician must disclose the record to the patient consistent with state and federal laws.

(C) The physician must follow applicable state and federal statutes and regulations for medical recordkeeping and confidentiality.

Section 9. Fraud and Abuse

(A) The physician must follow applicable state and federal statutes and regulations for fraud and abuse.

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Section 10. Effective. This Act shall become effective immediately upon being enacted into law.

Section 11. Severability. If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

Adopted November 2014; revised November 2015.

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ATTACHMENT 5

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FEDERATION OF
ATE MEDICAL BOARDS

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup

Adopted as policy by the Federation of State Medical Boards in April 2014

INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)[1] and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients[2] via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

[1] *The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).*

[2] *The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.*

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MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider.[3] However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.[4]

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.[5]

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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[3] *See Center for Telehealth and eHealth Law (Ctel), http://ctel.org/ (last visited Dec. 17, 2013).*

[4] *Id.*

[5] *See Cal. Bus. & Prof. Code § 2290.5(d).*

- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.[7]

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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[6] *American Medical Association, Council on Ethical and Judicial Affairs, Fundamental Elements of the Patient-Physician Relationship (1990), available at http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf.*

[7] *See Ctel.*

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Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

Licensure:
A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.[8]

Establishment of a Physician-Patient Relationship:
Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

Evaluation and Treatment of the Patient:
A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:
Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

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[8] *Federation of State Medical Boards, A Model Act to Regulate the Practice of Medicine Across State Lines (April 1996), available at http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf.*

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Continuity of Care:

Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services:

An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records & Exchange of Information:

Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information," issued by the Department of Health and Human Services (HHS).[9] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

[9] *45 C.F.R. § 160, 164 (2000).*

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results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:
Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit form that pharmacy.

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Prescribing:

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Section Five. Parity of Professional and Ethical Standards

Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician's practice.

A physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.

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FEDERATION OF
STATE MEDICAL BOARDS

January 8, 2019

Senator Judy Lee, Chairwoman
Human Services Committee
North Dakota State Senate
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Chairwoman Lee and Members of the Committee,

On behalf of the Federation of State Medical Boards (FSMB), I would like to take this opportunity to comment on Senate Bill 2094. The FSMB urges the Committee to support this legislation.

The FSMB is a national, non-profit organization whose members include the 70 state medical and osteopathic licensing and disciplinary boards of the United States and its territories, and the District of Columbia, including the North Dakota Board of Medicine. The FSMB serves as a collective voice for state medical boards with the goal of improving and advancing the nation's state medical regulatory system.

The FSMB provides a variety of services to support state medical boards in carrying out their statutory responsibilities to protect the public, including developing model policies and identifying "best practices" for states. As such, the FSMB is well positioned to comment on Senate Bill 2094.

In 2014, the FSMB's House of Delegates unanimously approved the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.* This policy was developed by a workgroup comprised of members and senior staff of state medical boards, representatives from the telemedicine provider community and legal experts. A draft was distributed to FSMB member boards and other stakeholders for comment prior to its adoption. The *Model Policy* is therefore a consensus document providing guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educating licensees as to the appropriate standards of care in the delivery of medical services directly to patients via telemedicine technologies.

Senate Bill 2094 reflects the standards adopted in the *Model Policy*, specifically in the following areas:

- The *Model Policy* defines telemedicine as, "the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of

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secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient." Both Section 2 (§43-17-01 (5)) and Section 3 (§43-17-02.3(3)(a)) of SB 2094 meet the guidelines established within the *Model Policy*.

- The *Model Policy* states, "the [physician-patient] relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient." It continues to state that "a physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient." SB 2094, specifically Section 4 (§43-17-44(2)), adheres to FSMB's *Model Policy*.

- The *Model Policy* states, "prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person." Section 5 (§43-17-45) of SB 2094 meets the guidelines adopted within the *Model Policy*.

For the aforementioned reasons, the FSMB believes that Senate Bill 2094 will reduce regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while protecting the public's health and safety.

Again, I thank you for the opportunity to comment on Senate Bill 2094 and urge you to support this legislation.

Sincerely,

Humayun J. Chaudhry, DO, MACP

Humayun J. Chaudhry, DO, MACP
President and Chief Executive Officer

cc: Members of the North Dakota Senate Human Services Committee

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ATTACHMENT 6

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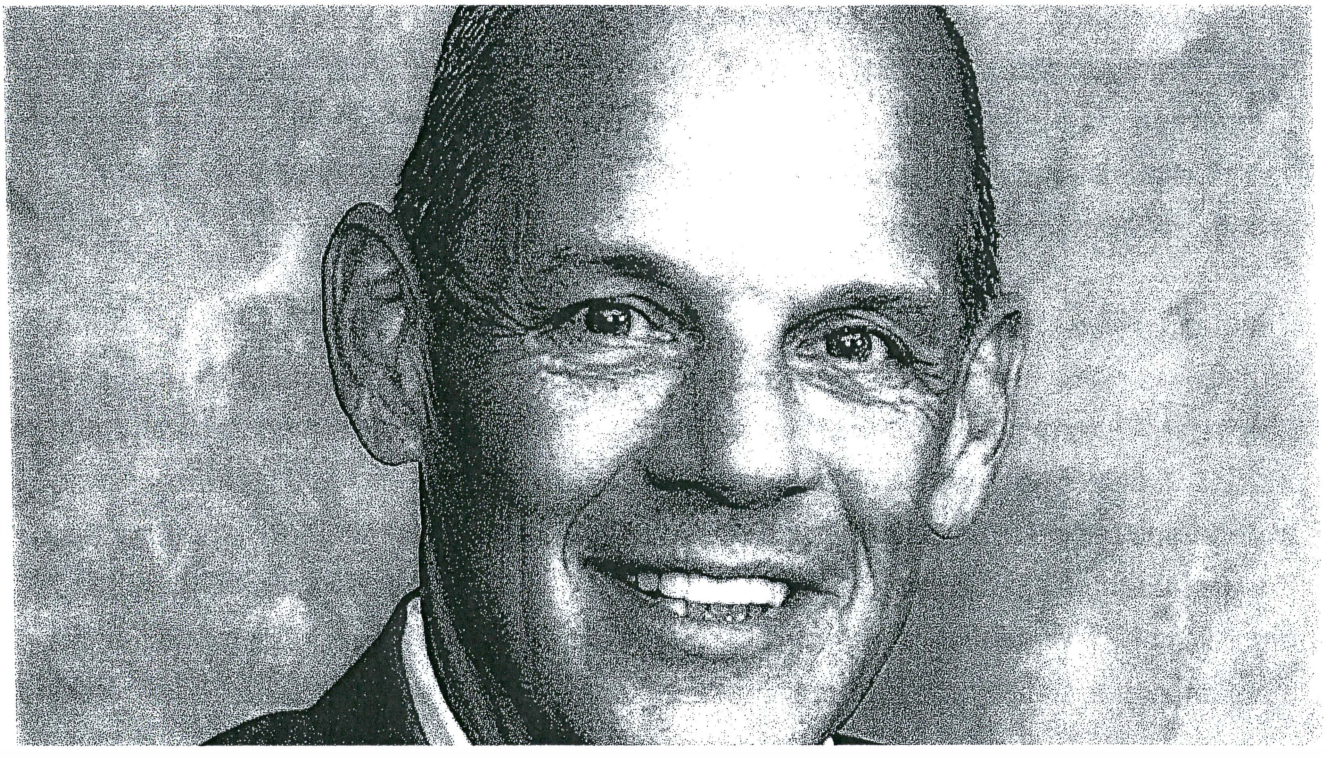
Severe Weather Announcements (3)

Letter: Lack of broadband access? Not in N.D.

By **David Crothers** on Apr 28, 2018 at 8:31 a.m.



By David Crothers

This month, the Forum Communications Co. publication Agweek wrote that "39 percent of Rural Americans lack access to Rural Broadband." That is debatable and subject to interpretation on a nationwide basis but is wildly inaccurate in North Dakota.

North Dakota quite possibly has the most "connected" rural broadband infrastructure and

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residents of any state in the country. As you will recall, it was just a month ago (March 21)

Gov. Doug Burgum announced that North Dakota would be the first state in the nation to

connect every school—elementary, middle, high school and institution of higher education—with Gig (gigabit) service.

Gigabit service, it is often said, is about 100 times faster than most homes in the United States have today. The Federal Communications Commission defines "broadband" as being 25 megabits downstream and three megabits upstream. Gigabit is 1,000 megabits downstream, or 40 times faster than the U.S. Government's own definition of broadband. North Dakota's telecom cooperatives and small commercial companies offer gigabit service in 288 communities today.

That tremendous feat is only possible because of the existing broadband infrastructure and a billion-dollar investment by telecommunications cooperatives and other independent and locally- owned telecom providers. Those 18 companies serve 96 percent of North Dakota's geographic territory and employ over 1,000 men and women. That local ownership is critical. The decisions on where to invest and how much are made around boardroom tables in Carrington and Park River and Hazen instead of somewhere else in the nation by someone who has never visited North Dakota, much less appreciates the importance of a state of the art broadband network for rural residents. The dollars earned in North Dakota are reinvested in the broadband infrastructure and the customers they serve. No one understands the critical need for affordable access to high-speed Internet for their educational, economic, medical and entertainment opportunities more than rural residents.

Those North Dakota-based telecom companies providing broadband in the highest-cost, lowest- density areas of the state don't just take that fiber-based infrastructure to schools or the most profitable customers or the edge of town. They are committed to ensuring that all residents of the state have access to it. It is as important for a rancher to be able to buy through online auctions as it is for a home health care nurse to be able to send images to a big city physician from a patient's home or students connect with online educational for

video instruction. Locally- owned broadband providers recognize that and design a network to make sure they are not forgotten.

David Crothers, of Mandan, is executive vice president of the North Dakota Association of Telecommunications Cooperatives.

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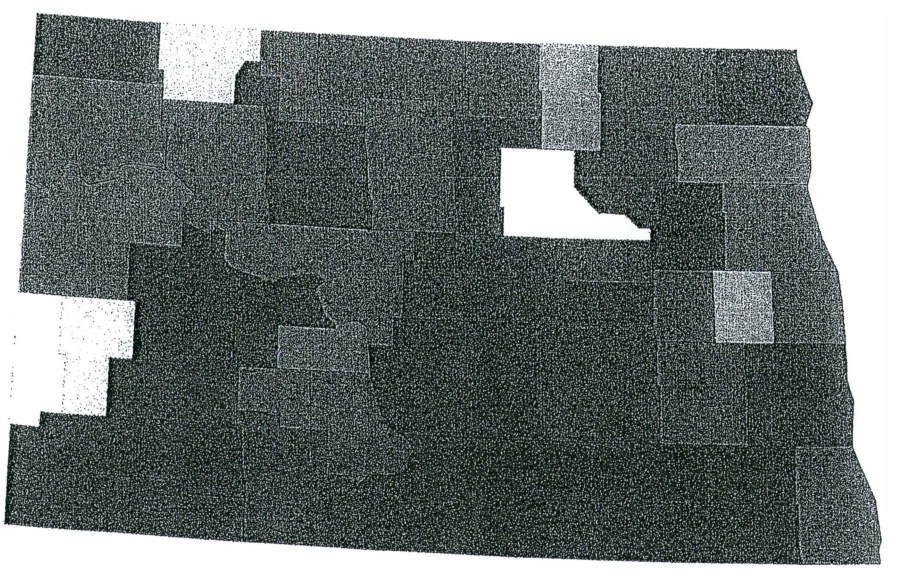
COVERAGE BY COUNTY



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25+ mbps | 100+ mbps | 1 Gbit

BROADBAND COVERAGE

POPULATION UNDERSERVED

31.7

MBPS AVERAGE
STATE-WIDE SPEED

17th

MOST
CONNECTED STATE

BROADBAND SPEEDS

93.5% of North Dakotans have access to wired broadband 25mbps or faster.

91.6% of North Dakotans have access to broadband 100mbps or faster.

72.3% of North Dakotans have access to 1 gigabit broadband.

WIRED COVERAGE

97.0% of North Dakotans have access to wireline service.

41.8% of North Dakotans have access to fiber-optic service.

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[illegible]% of North Dakotans have access to [illegible] service.

70.7% of North Dakotans have access to [illegible] service.

WIRELESS COVERAGE

100.0% of North Dakotans have access to [illegible] service.

48.0% of North Dakotans have access to [illegible] service.

LARGEST COMPETING PROVIDERS IN NORTH DAKOTA

1. [illegible]

TOP 5 FASTEST CITIES IN NORTH DAKOTA

	City	Avg. Download Speed	No. of Providers
1.	[illegible]	93.8 MBPS	8 Providers
2.	[illegible]	86.8 MBPS	7 Providers
3.	[illegible]	77.2 MBPS	7 Providers
4.	Golden Valley	70.3 MBPS	7 Providers
5.	[illegible]	64.1 MBPS	8 Providers

SPEEDS FOR MAJOR PROVIDERS IN NORTH DAKOTA

Provider	Avg. Download Speed
[illegible]	38.3 MBPS
[illegible] Communications	25.7 MBPS
[illegible] Communications	22.2 MBPS
Consolidated Communications	13.8 MBPS
CenturyLink	7.1 MBPS

GOV'T FUNDING

Since 2010, [illegible] has been awarded $3,664,087 in federal grants for [illegible].

Another $10,781,157, accounting for 0.3% of all federal infrastructure grants, was awarded to broadband infrastructure projects in North Dakota.

Since 2011, access to a wired connection of at least 10mbps has improved from 78.8% to 95.2% of North Dakotans.

QUICK STATS

In total there are 92 internet providers in North Dakota.

There are 45,000 people in North Dakota without access to a wired connection capable of 25mbps download speeds.

There are 178,000 people in North Dakota that have access to only one wired provider, leaving them no options to switch.

Another 21,000 people in North Dakota don't have any wired internet providers available where they live.

Sources: Data collected via the FCC, NTIA, and other sources. For a full list of data sources please visit our data page.

NORTH DAKOTA CITIES

City	Broadband Coverage	Average speed over time	# of Providers
[redacted]	99.7%		6 providers
[redacted]	99.4%		12 providers
[redacted]	99.3%		8 providers
[redacted]	100.0%		10 providers
Fargo	99.6%		16 providers
Grafton	80.0%		9 providers
Grand Forks	91.8%		13 providers
Jamestown	99.0%		9 providers
Mandan	91.7%		9 providers
Minot	96.5%		8 providers

City	Broadband Coverage	Average speed over time	# of Providers
[illegible]	98.6%		7 providers
[illegible]	100.0%		8 providers
[illegible]	99.1%		11 providers
[illegible]	82.6%		10 providers
[illegible]	99.2%		14 providers
[illegible]	94.9%		8 providers

COPY LINK TO CLIPBOARD

https://broadbandnow.com/North-Dakota

[illegible] › North Dakota

Last Updated on 11/13/2018.

Cite this page

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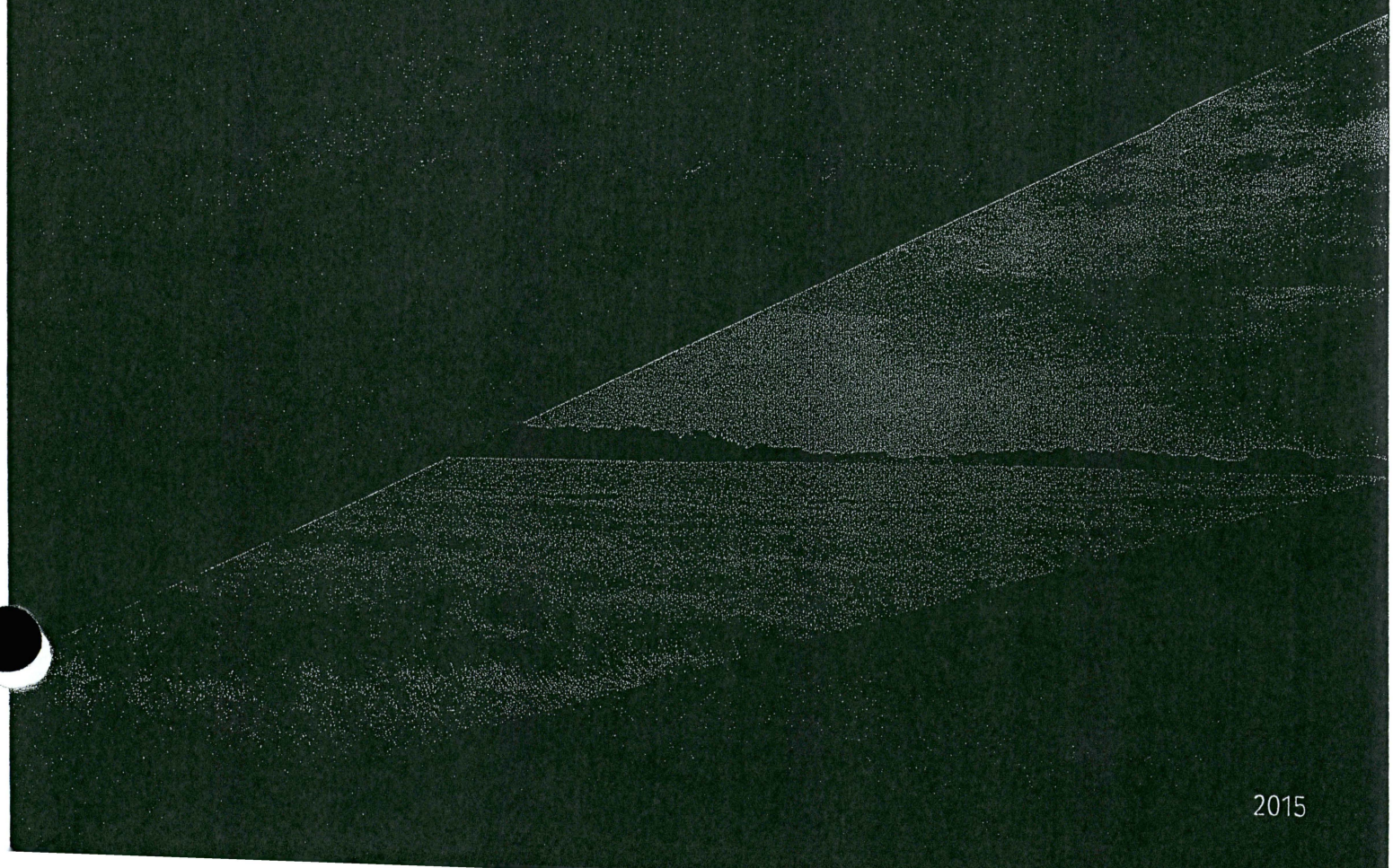
North Dakota Broadband Report

Connecting the World to North Dakota



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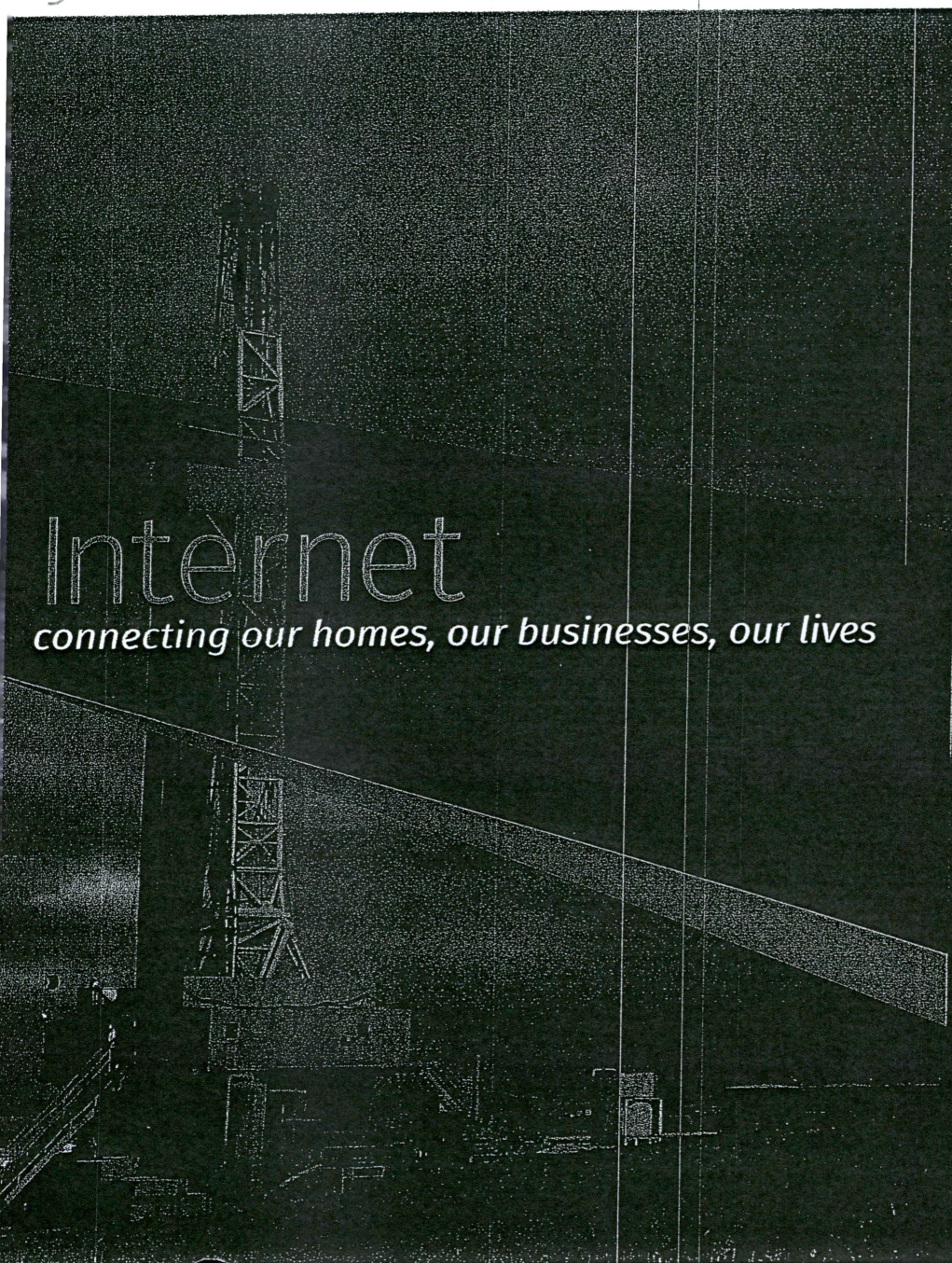

Internet

connecting our homes, our businesses, our lives

At its best, human connection is what the Internet is all about. ***It's the video that goes viral*** that you can't wait to share with your friends. It's sending ***photos of your kids*** to your parents, who won't believe how they've grown. It's ***catching up with old friends*** on Facebook. It's sending that email at work that ***helps your business grow.*** It's ***streaming that movie online*** on a Saturday night with your kids and your spouse. It's the attachment that ***makes the whole office cheer.*** It's the ***article*** you send to a friend who has just been diagnosed. It's the ***video chat*** with your son overseas in the military. The Internet is woven into the fabric of our days, and ***we can't imagine life without it.***

This North Dakota Broadband Report shares the ***good news:*** the availability of high speed broadband Internet and fiber-to-the-home technology is ***booming*** in North Dakota. The report also tells the stories of ***people like you***—businesswomen and men, people working from their homes, people trying to make their lives work, people looking for ***human connection***—and how North Dakota's Internet infrastructure has ***changed their lives for the better.*** In every case, ***the story is the same:*** individuals and businesses throughout North Dakota are thriving because of the connection broadband offers.

Your Internet connection isn't something you should have to worry about, or even think about. It should be there for you, like a ***reliable friend.*** This report shows that, without a doubt, ***you have a friend in North Dakota's broadband networks.***

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From the Acting Administrator
of USDA Rural Utilities Services

"To have a United States of America, we must have a connected America.

"Access to a high-speed connection will fundamentally change the way we live, work, and do business.

We are fortunate to live in a country that has always believed that to have a United States of America, we must have a connected America. Policies have been adopted to join rural and urban areas together through telephone, electricity and interstate highway systems. That tradition continues today in a 21st century context, with the deployment of high-speed broadband Internet.

Substantial investments have been made during the past five years to build out North Dakota's broadband network. The USDA Rural Utilities Service, with our partners, has positioned North Dakota as the leading state in coverage, speeds and fiber-to-the-home access. This cutting edge network doesn't happen alone; it takes a team of partners. As featured in this report, the vision and leadership of the North Dakota Telecommunications providers has prepared the state well for a prosperous future.

Access to a high-speed connection will fundamentally change the way we live, work, and do business. It opens up opportunities to telework or start a business. Our farmers and ranchers have access to real-time market information. Distance learning offers students access to more classes and the chance to obtain a degree from home. The high-speed connection also opens the door to telemedicine opportunities that never existed before. Of course, there are also the social benefits—staying connected to their friends and loved ones.

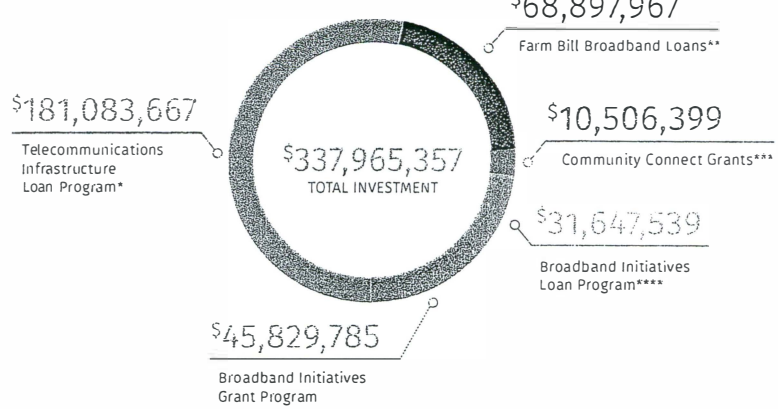
Please enjoy this North Dakota Broadband Report, which highlights the substantial work already done and the work left to do. Once again, North Dakota is leading the way.

Jasper Schneider
Acting Administrator
USDA Rural Utilities Service

Broadband Investments in North Dakota

Broadband is the infrastructure of the 21st century. Since 2009, USDA has invested more than $330 million in North Dakota telecommunications and broadband projects, of that total investment, more than $56 million was granted and $281 million was loaned to local North Dakota Internet service providers to help build out and provide better service to their customers. These investments provide economic development, educational, health care, social and public safety benefits to improve the quality of life for North Dakotans

USDA Telecommunication Programs



* The Telecommunications Infrastructure Loan Program makes long-term direct and guaranteed loans to qualified organizations for the purpose of financing the improvement, expansion, construction, acquisition, and operation of telephone lines, facilities, or systems to furnish and improve telecommunications service in rural areas.

** The Farm Bill Broadband Program is designed to provide loans for funding, on a technology-neutral basis, for the costs of construction, improvement, and acquisition of facilities and equipment to provide broadband service to eligible rural communities.

*** The Community Connect program serves rural communities where broadband service is least likely to be available, but can make a tremendous difference in the quality of life for citizens. The projects funded by these grants will help rural residents tap into the enormous potential of the Internet.

**** The Broadband Initiatives Program (BIP) was established in response to the American Recovery and Reinvestment Act of 2009 (Recovery Act). The primary goal of the Recovery Act was to provide a fiscal boost to the nation during the economic crisis. Providing access to broadband services will increase economic development and improve the quality of life for all Americans. BIP funding for loans, grants, and loan/grant combinations will help address the challenge of rapidly expanding the access and quality of broadband services across rural America and meeting the objectives of the Recovery Act.

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From the Chief Executive Officer
of Dakota Carrier Network

"DCN's high-speed network enables businesses to compete on a worldwide stage as data travels across North Dakota or around the world.

"DCN provides network connectivity to North Dakota's most critical institutions.

Dakota Carrier Network's fiber optic network promotes business opportunities. Dakota Carrier Network (DCN) and its 15 independent rural telephone companies are committed to serving the citizens of North Dakota—it's the reason we have collectively invested more than $100 million per year in fiber infrastructure for the last decade. This $1.3 billion investment to put 40,000 miles of fiber optics in the ground extends ultra-high-speed broadband capabilities to every corner of the state. DCN's high-speed network enables businesses to compete on a worldwide stage as data travels across North Dakota or around the world.

The State of North Dakota recognizes this investment in technology and deploys DCN's network to bring gigabit-capable broadband services to 300+ locations across the state including state agencies, higher education institutions, and K-12 school districts.

DCN's fiber optic network is supported 24 hours a day, seven days a week by industry-certified, highly skilled technicians in a state-of-the-art Network Operations Center in Bismarck. DCN's carrier-grade-hardened facility is engineered to meet and exceed high availability standards. This is crucial since DCN provides network connectivity to North Dakota's most critical institutions, including health care, public safety, state government, schools, and financial organizations among others relying on broadband service to perform their daily business activities.

DCN and its member companies will continue to invest, upgrade and provide world-class broadband service to North Dakota consumers.

Seth Arndorfer
Chief Executive Officer
Dakota Carrier Network (DCN)

From the Executive Vice President
of the North Dakota Association of Telecommunications Cooperatives

"Today's rural customer requires an array of sophisticated offerings to access the entertainment, educational and economic opportunities others in the world enjoy.

"Every rural North Dakotan will have access to gigabit speed by 2019.

The 18 independent telecommunications companies in North Dakota have long demonstrated a commitment to meeting the evolving needs of their members and customers. In the past, the telecom cooperatives and small commercial companies satisfied all of their consumers' needs by providing quality, affordable phone service. Those days have long passed—today's rural customer requires an array of sophisticated offerings to access the entertainment, educational and economic opportunities others in the world enjoy.

The challenge is huge—cooperative and small commercial members serve 96 percent of the state's geographic territory—and the investment is substantial. Yet there are no alternatives to this investment: in the past, telecom companies offered a menu of services from which customers could pick and choose. Today, that same consumer determines the services they want and how much they are willing to spend for speed, capacity and content.

North Dakota independent telecom companies have responded aggressively, in many cases with the assistance of USDA Rural Development offices. Each company in the state is committed to building out fiber-to-the-home in the shortest time possible. Several telcos have a 100% fiber network and more will be added each year until—we predict—every rural North Dakotan will have access to gigabit speed by 2019.

Today, our customers hold online livestock auctions, watch movies, participate in classes at top universities and send vast amounts of research data across our networks. We don't know how they will use our network in the future, but we are committed to building the infrastructure that allows them to meet their needs.

David Crothers
Executive Vice President/General Manager
North Dakota Association of Telecommunications Cooperatives (NDATC)

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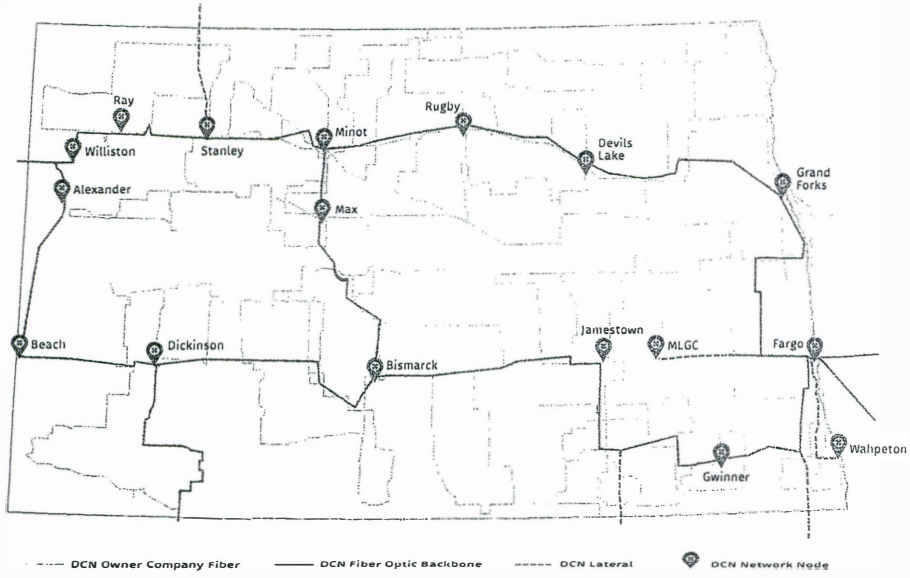
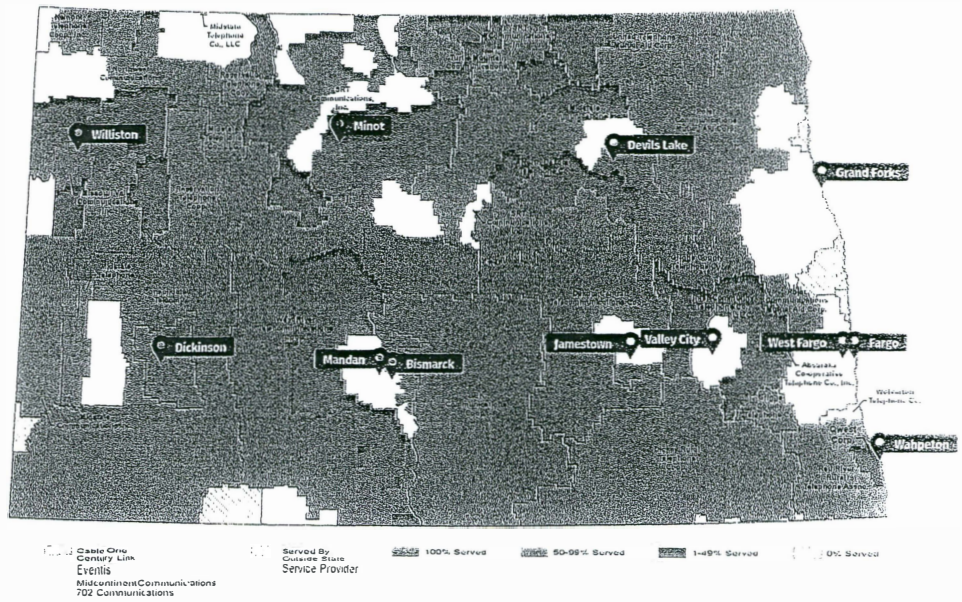
Broadband
Capacity Maps

On average in the United States, only 5% of households have fiber Internet, but the maps below illustrate the remarkable coverage of fiber in North Dakota. As the coverage map shows, local telcos provide fiber to most of our state's rural areas, in many areas offering 100% coverage. In other words, in these communities 100% of homes and businesses are fiber-ready. The fiber backbone map reveals the immense network created by these telcos, which branches off the Dakota Carrier Network.

North Dakota-
Backbone Fiber



North Dakota-
Exchanges Served by Fiber



*Fiber To The Home (FTTH) deployed by end of year 2015. Map data based on area served.

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How Broadband
Connects Our Lives

Connecting to nature:
where the song birds sing and the data streams

Perched atop 16,000 acres of rolling hills and lush wetlands, the visitors center at the Arrowwood National Wildlife Refuge hosts thousands of schoolchildren, hikers, bird watchers and nature enthusiasts every year. Wetland district manager Stacy Whipp has the best of both worlds: a rewarding career in the great outdoors and a fiber connection to help her track species, report data and preserve natural resources. "Having a broadband connection has been fantastic," Stacy says, "It's enabled us to get data from a wide variety of places. Before we had to ship CDs, and now they can drop it right onto our server." The connection Arrowwood enjoys allows them to link sister stations within the Refuge grounds while connecting beyond its boundaries.

Connecting through education:
head of the class

The mission of the K-12 Ellendale Public School is to develop adaptive citizens for an ever-changing world by providing challenging opportunities to reach or exceed expectations.

Technology is fully integrated into the learning process, with all levels using tablet computers and programs such as Learn 360, Brain Pop and Ellendale Webcasts. Jeff Fastnacht, Superintendent, says, "We are very proud of our technology integration in our school... Our daily life is filled with the Internet and technology just as much as California or New York, and we have better access." Even though the median household income of the student population is only $35,500, these children are using advanced technologies to further their education.

Connecting to new industry:
North Dakota's black gold

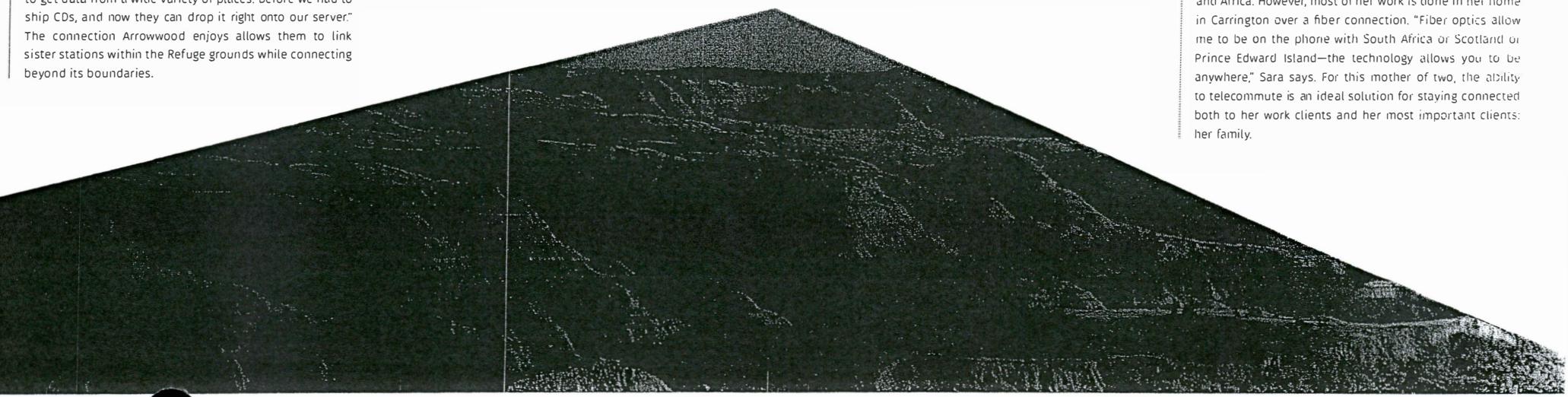
Enduro Operating, LLC is an oil and gas exploration and acquisition/exploitation company near the town of Newburg, population 100. Their previous T1 connections were costing the company thousands of dollars per month and providing minimal speeds. To conduct their day-to-day operations more efficiently and maintain constant communication with their headquarters in Fort Worth, they upgraded to fiber. "Our entire operation is dramatically faster," said Rob Braun, Director of Information Technology. "We recently ran speed tests and are showing speeds of up to 300 Mbps – something we'd never seen prior to fiber, nor would we have ever been able to get." Braun attributes running successful off site backups to fiber.

Connecting to grow:
harvesting the fruits of fiber

Wade Hohertz's company in Mott switched from copper cable to fiber optics in June 2010. Previously, with a satellite Internet connection, the company experienced service disruptions on rainy or cloudy days due to weather-related outages. As a crop insurance adjuster, Wade's work depends on a reliable Internet connection. "We have not had one outage since fiber was installed. All my work is on the Internet uploading and downloading claims. Sending files was so frustrating, because I would try for hours and hours to send my files. My company offers many online training classes, but before fiber it would take forever to participate. Having fiber has changed my life, and I love it!"

Connecting from the home:
international businesswoman and local mom

North Dakota is the main sunflower-growing region for Technology Crops International, a supply chain management firm for the global distribution of seed oil. As General Manager of the North American Division, Sara Anderson's job occasionally takes her to South America, Europe, Asia and Africa. However, most of her work is done in her home in Carrington over a fiber connection. "Fiber optics allow me to be on the phone with South Africa or Scotland or Prince Edward Island—the technology allows you to be anywhere," Sara says. For this mother of two, the ability to telecommute is an ideal solution for staying connected both to her work clients and her most important clients: her family.



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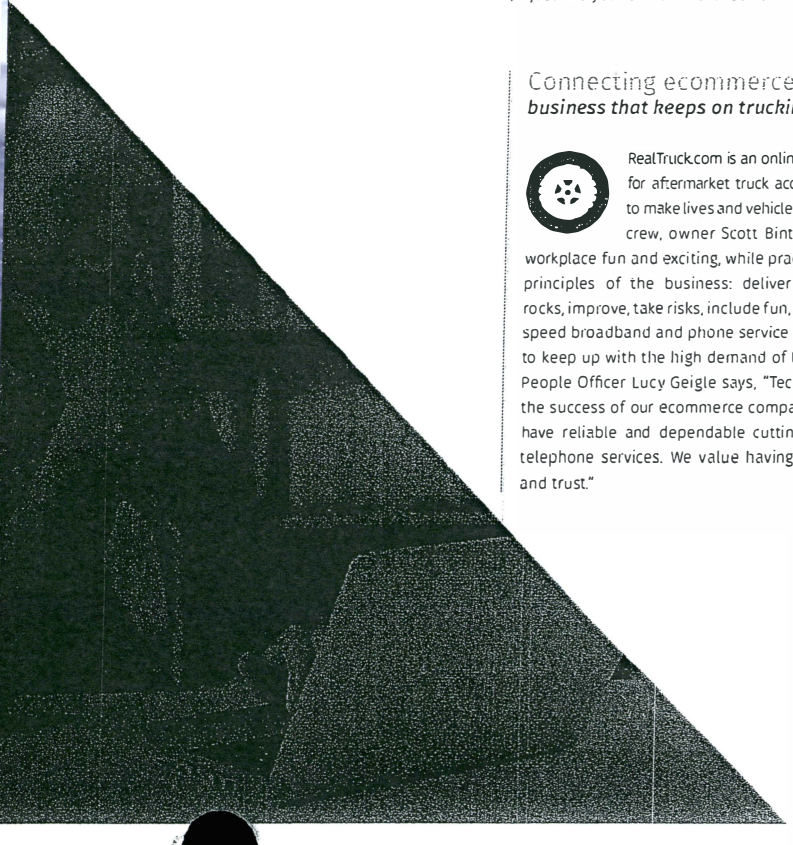
Connecting for our lives:
mixing office and home to make things work

Mary Jo Wicks, a nurse practitioner at the women's clinic of St Joseph's hospital, was thrilled to get fiber installed in her Richardton home. Before the fiber installation, Mary Jo would stay late at the clinic to finish paperwork because she had no reliable Internet at her home to complete the day's paperwork. Leaving the clinic around 8 p.m. each evening, Mary Jo would miss dinner with her husband and kids. With fiber-to-the-home, she enjoys a family meal, spends the evening with her husband and children and then takes care of paperwork after the kids are asleep. "Fiber has improved our quality of life 100%!"

Connecting to family:
from Brazil, with love

Ultimately, the Internet is about connecting not only our businesses, but our lives as well. When Soraia Henson moved to Carrington, North Dakota from Brazil, she left behind a large circle of family and friends, not to mention the tropical weather. Adjusting to the winters, though, has been easy compared to life without her social network. But today, Soraia sees her friends and family daily using a webcam over a fiber connection. She even organizes video chat rooms, filled with familiar faces, all gabbing together in Portuguese! "It's the best thing that's ever happened in our life," Soraia says, "because it's easy and you can see just like you're in the next room."



Connecting ecommerce:
business that keeps on truckin'

RealTruck.com is an online retailer in Jamestown, for aftermarket truck accessories, on a mission to make lives and vehicles better. Along with his crew, owner Scott Bintz strives to keep the workplace fun and exciting, while practicing the six guiding principles of the business: deliver more, transparency rocks, improve, take risks, include fun, and be humble. High-speed broadband and phone service allows RealTruck.com to keep up with the high demand of the industry. As Chief People Officer Lucy Geigle says, "Technology is critical to the success of our ecommerce company. It is important to have reliable and dependable cutting-edge Internet and telephone services. We value having a partner we know and trust."

Thank You
to Our Sponsors

Thank you to the sponsors of the North Dakota Broadband Report—USDA, NDATC, DCN and the telecommunications companies that make North Dakota a leader in Internet connectivity.

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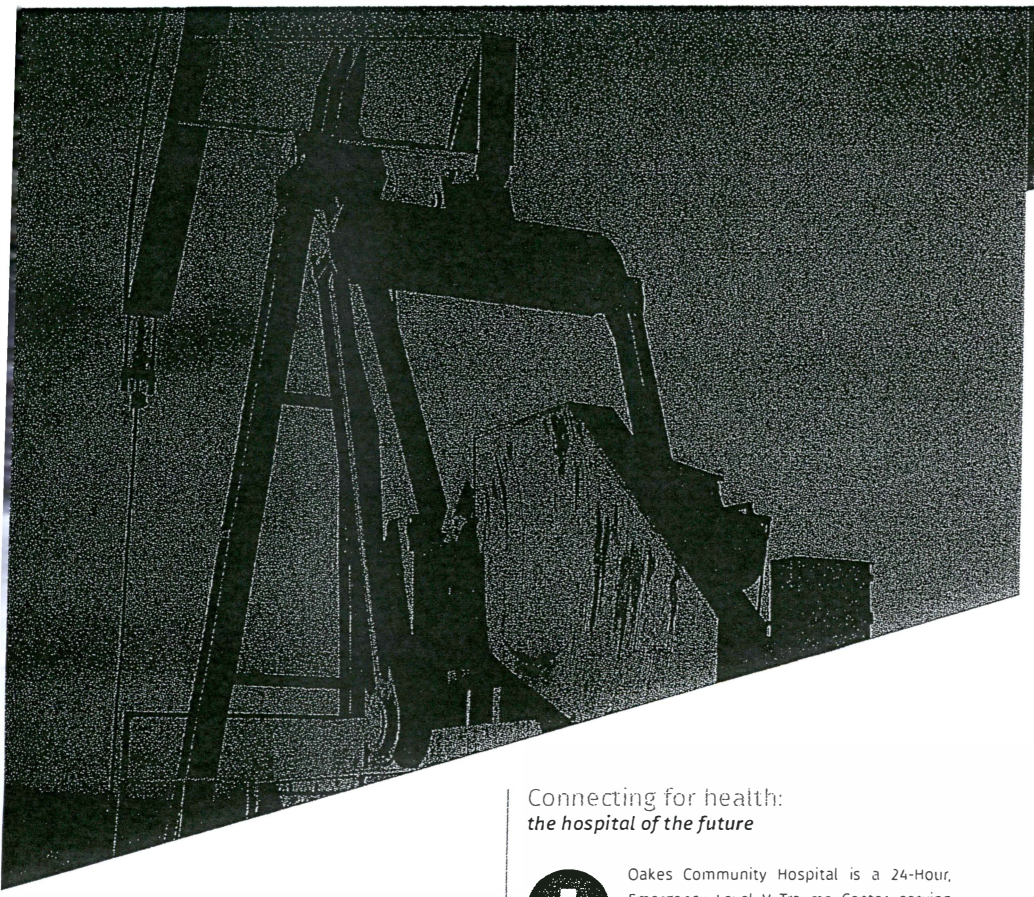
USDA United States Department of Agriculture

NDATC

DCN Dakota Carrier NETWORK



Connecting systems:
Internet through the pipes

BakkenLink Pipeline LLC has worked with their provider to establish fiber connections along their pipeline systems. This connection works through the Dakota Carrier Network, which connects BakkenLink to the world. Darren Snow, Vice President of BakkenLink, says, "These circuits tie into our supervisory control and data acquisition system, which provides oversight of our pipeline. The circuits enable us to run the most current versions of pipeline leak detection software, which allows us to see real-time data on the pipeline and run transient models to look for leaks in real time."

Connecting for health:
the hospital of the future

Oakes Community Hospital is a 24-Hour, Emergency Level V Trauma Center, serving approximately 14,000 people in southeastern North Dakota. The medical staff consists of providers who are multi-specialists in family practice, internal medicine, cardiology, sports medicine and geriatrics. The hospital uses fiber optic broadband and other advanced technologies to diagnose conditions and provision services. Oakes Community Hospital was the first North Dakota hospital to roll out and utilize e-emergency—which allows doctors to video conference with other doctors and specialists directly in the treatment room—and other technologies like e-Consultation and PADNet.

Connecting small to large:
big business in a town of 427

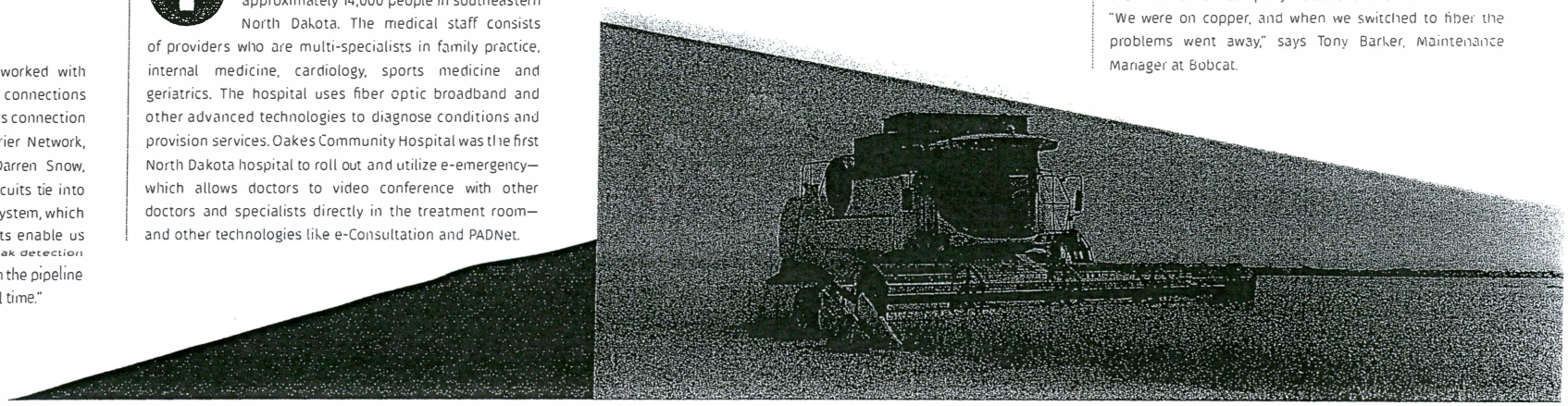
Basin Service Company Inc., located south of Westhope (population 427), is an oil field service company providing a variety of services to the oil industry. The company, founded as Ward Williston in the 1950s, has remained a constant in the small community through the years. Basic switched from copper to fiber, allowing them to have faster Internet speeds than ever, clearer phone calls, and a new way of doing business. Jean Brandt, Human Resources Administrator, says, "In the past, it could take days to do bookkeeping. Some of our employees could only do certain functions at the same time or we'd have too many people on the system and it wouldn't work." She noted that though this company chose to locate their office near a small town, they can still conduct business like companies in major cities.

Connecting for livelihood:
three businesses from one home office

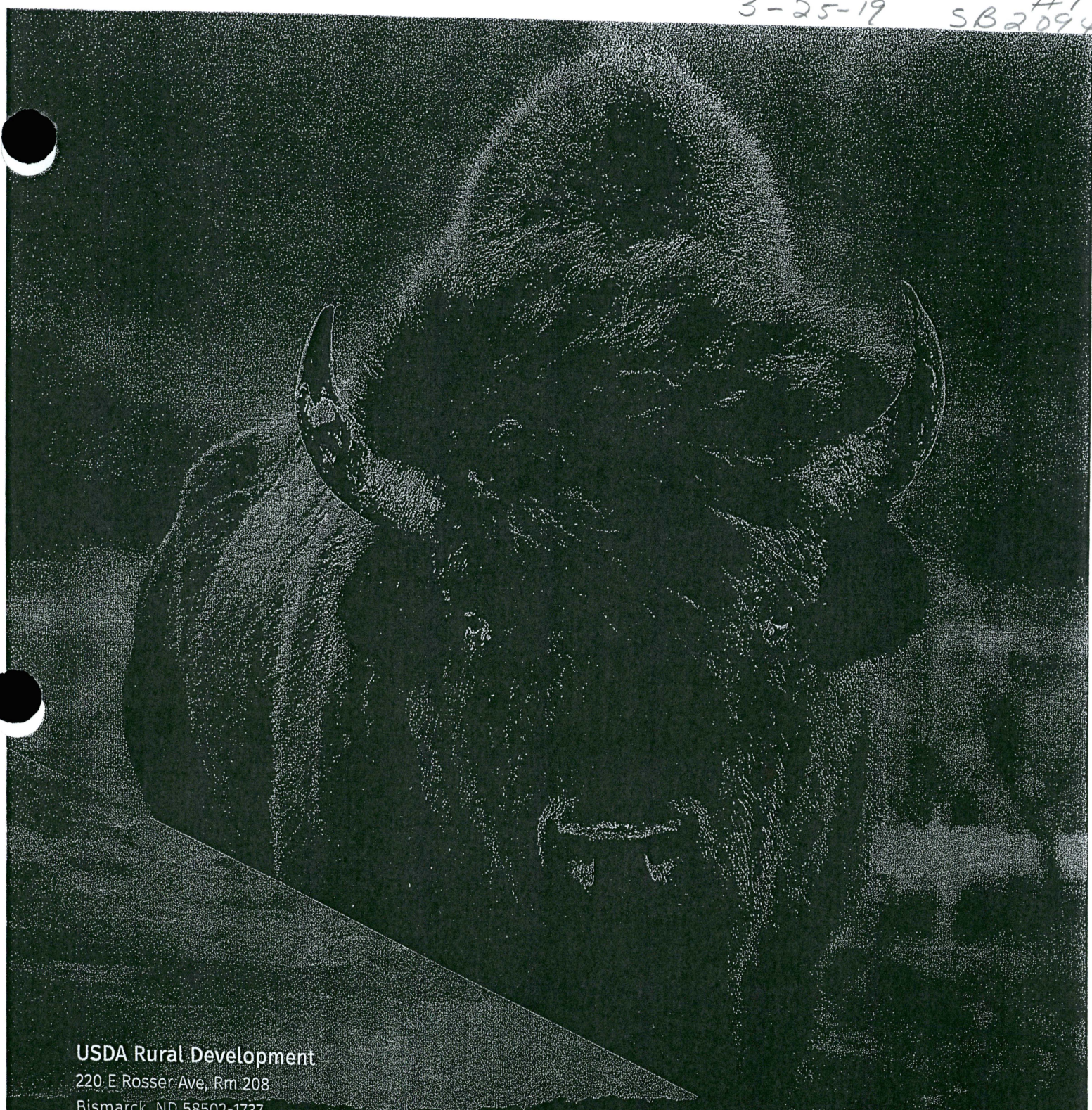
Laura Shipley lives in Kidder County, where she and her family run three businesses from their home: a farm/ranch operation, an electrical contracting business called Shipley Electric, and a small photography business called Snap Shots Photography. Given harsh winters and road closings, being able to work from home is, as Laura puts it, "an awesome benefit – we rely on our high speed Internet for our livelihood. It puts us on a level playing field with cities that have the advantage of advanced technology. We have access to everything they do and we're able to keep up with them and be competitive!"

Connecting to build:
Bobcat spotted in North Dakota

A giant animal has been spotted in Gwinner! But don't worry, it won't bite. This animal is Bobcat Company, North Dakota's largest manufacturer, with the most extensive compact equipment distribution network in the world. The low cost of living, abundant community resources and access to a dedicated labor force of more than 1,500 employees are ideal conditions for Bobcat's production facility in Gwinner to thrive. Their fiber connection links them to other company locations around the world. "We were on copper, and when we switched to fiber the problems went away," says Tony Barker, Maintenance Manager at Bobcat.



3-25-19 SB2094 #1



USDA Rural Development
220 E Rosser Ave, Rm 208
Bismarck, ND 58502-1737
701.530.2037
info@nd.usda.gov
www.rurdev.usda.gov/ND

North Dakota Association of Telecommunications Cooperatives
3201 Nygren Dr. NW, PO Box 1144
Mandan, ND 58554
701.663.1099
www.ndatc.com

Dakota Carrier Network
4202 Coleman St.
Bismarck, ND 58503
701.258.2124
www.dakotacarrier.com

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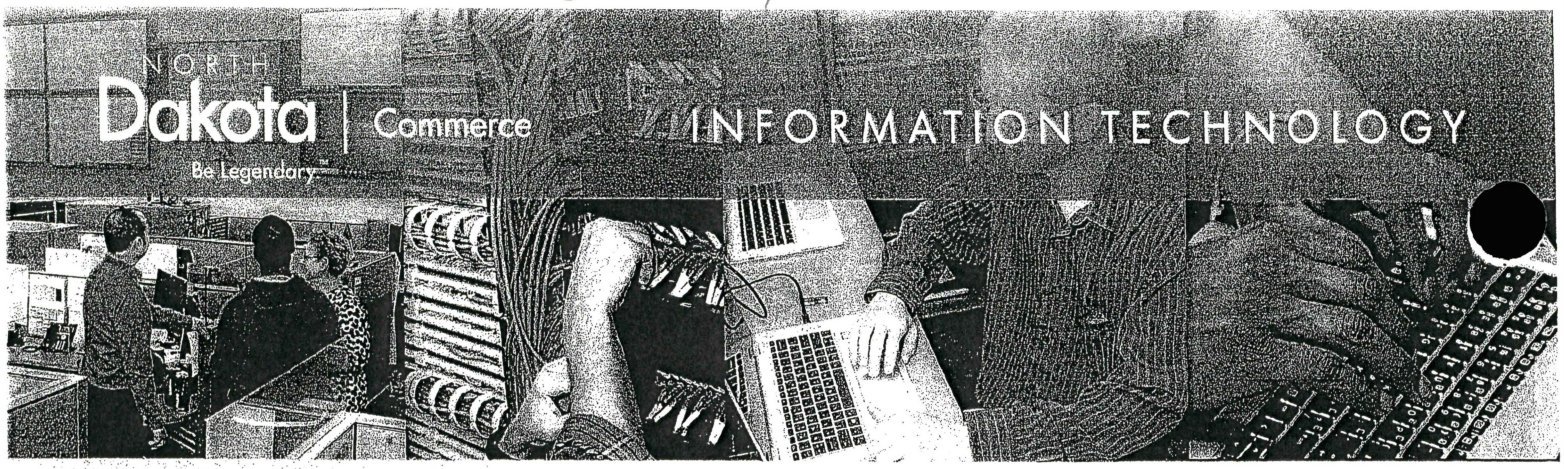

INDUSTRY FACTS

$938 MILLION BROADBAND INVESTMENTS PAST 5 YEARS

75% NORTH DAKOTANS WITH GIGABIT INTERNET ACCESS

21,744 JOBS IN TECHNOLOGY SUBSECTORS

6% OF THE STATE'S GDP

NORTH DAKOTA'S TECHNOLOGICAL PROWESS

Information Technology, as well as technology subsectors, have rapidly become one of North Dakota's largest industries and continue to be a driver for all sectors of the state's economy. In addition, IT is a major center for innovation that stimulates job growth in areas like agriculture, healthcare, energy production and autonomous systems. Job growth in IT has increased by 11% over the past decade where start-up activities have become plentiful. The state's technology subsectors employ approximately 22,000 people across 3,000 businesses, including the nation's second-largest Microsoft campus. In addition, IT and technology contribute approximately $3 billion per year to the state's Gross Domestic Product with annual wages averaging $62,000 per employee. Over the last decade, North Dakota has enjoyed a 27-percent increase in technological applications and is projected to realize 20-30 percent more growth over the next 10 years. This is due to significant cluster development and growth in areas such as mobility (autonomous systems), computer and cyber sciences, and cybersecurity. Also, the state's energy and agriculture industries have become highly integrated with North Dakota based technological firms offering operational efficiencies via sophisticated advanced manufacturing capacity.

CONTRIBUTING GROWTH FACTORS

North Dakota has achieved and sustained growth in the IT sector for several reasons. In 2018, two new data centers were constructed, significantly expanding storage capacity. North Dakota is a national leader in broadband activity with almost $1 billion invested in infrastructure coupled with the state likely becoming the first to achieve one-gigabit connectivity for all school districts. In addition, North Dakota is the first state to adopt the Cyber Sciences Initiative where students will be provided with the technological skills needed to meet future workforce needs. Within higher education, Bismarck State College teamed up with Palo Alto Networks, a global cybersecurity leader, to educate students for high in-demand jobs. At both UND and NDSU, undergraduate and graduate programs are offered within the Research Institute for Autonomous Systems and Computer Sciences College to further machine learning, artificial intelligence, cybersecurity and autonomous systems development. In addition, in December 2018, Governor Burgum announced a $30 million request to create the nation's first Beyond Visual Line of Sight (BVLOS) network in the United States for unmanned systems. As such, North Dakota has the progressive approach, infrastructure, educational institutions and workforce requirements to lead the nation in various IT and technical disciplines.

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DID YOU KNOW

Technology subsectors in North Dakota **employ 22,000 people** across 3,000 businesses, including the nation's second-largest Microsoft campus.

North Dakota is a **national leader in broadband** activity with almost $1 billion invested in infrastructure

IT and technology contribute approximately **$3 billion per year** to the state's Gross Domestic Product

Annual wages in IT average **$62,000**

SMALL COMPANIES WITH AN IMMENSE IMPACT

IT and technologically oriented firms have not only led to job creation but have supported statewide economic diversification while contributing to national and international Intellectual Property commercialization. Emerging technologies in sectors such as energy production, biomedical, UAS/Precision Ag, software development and defense tech are being developed and commercialized in North Dakota as a direct result of North Dakota's unique clusters.

Myriad Mobile (IT Development) — On May 15, 2018, Myriad Mobile received $7 million in individual funding. Myriad Mobile is an enterprise software development company specializing in agtech with a focus on design, development and strategy. The firm creates custom mobile-first software applications and technology platforms and has worked on over 600 projects since 2011. It employees almost 100 people.

Packet Digital (IT and Military Tech Development) — On April 26, 2018, Packet Digital received $9.69 million in individual funding. Packet Digital is a manufacturing company that specifically manufactures and markets circuits for power management in portable devices and embedded systems. The company works with customers in multiple industries including medical devices, consumer, and defense.

Steffes Corporation (Energy Tech) — Developed an Electric Thermal Storage (ETS) system that gains efficiency by taking advantage of off-peak electricity, which is charged at a lower rate since it is consumed during times when demand on the electrical grid is low. With Steffes ETS system's ability to store vast amounts of heat for long periods of time, customers enjoy on-peak performance for an off-peak price.

Baker Boy (Advanced Manufacturing Tech) — Baker Boy is bringing well-paying and highly skilled manufacturing jobs to North Dakota through innovative manufacturing practices driven by new technologies. Production capacity will increase from 5,000 donuts per hour to 22,000, adding approximately $15 million in sales per year.

Harris Corporation (UAS and Precision Ag) — Developed aviation-grade network services specifically for UAS operations which included a risk and safety assessment of UAS detect-and-avoid technology. The UAS BVLOS network will be developed within the Grand Forks-to-Fargo corridor. This technology is the proof-of-concept for a statewide network.

WHAT'S NEXT FOR IT AND TECH

North Dakota is making the requisite investments in infrastructure, K-12 education and in its university system to provide a solid foundation for industry to continue to grow; with projected increases of 20-30 percent in IT and technical positions, North Dakota will be positioned to have the necessary workforce in place to meet demand. To further growth prospects in IT and emerging technologies, the North Dakota Department of Commerce is leading an IP commercialization initiative with the Bank of North Dakota and University System to enable job creation, spinoffs into private industry and clustering of new companies that leverage research in emerging sectors. This will be accomplished through refining current IP commercialization efforts within the University System as well as bringing entrepreneurs, venture capital firms, researchers and industry together to grow this sector.

NORTH Dakota | Commerce
Be Legendary.
For more information, contact James Leiman at jleiman@nd.gov

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ATTACHMENT 7

#1
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3-25-19

Bonnie Storbakken

[redacted]om: Lynette McDonald
[redacted]nt: Sunday, December 30, 2018 8:05 PM
To: Bonnie Storbakken
Subject: Fw: Board of Medicine Meeting Highlights - November 2018

From: Darin Willardsen <willardsend@horizonvirtual.net>
Sent: Friday, December 28, 2018 10:36 PM
To: Lynette McDonald
Cc: Todd Severnak; Jeremy Skramsted
Subject: RE: Board of Medicine Meeting Highlights - November 2018

Bonnie,
Great to have the conversation with you a few weeks ago about the language pertaining to theprescribing of opioids through telemedicine only if done so as a federal Food and Drug Administration approved medication assisted treatment for opioid use disorder. In our line of work in providing telemedicine to rural hospitals as board certified admitting Internal Medicine physicians, we do see the absolute requirement forthe ability to [redacted]write for these medications on the inpatient unit at the time of admission.
[redacted]lease reconsider the wording on the current bill to exclude the practice of inpatient medicine on the restrictions for opioid prescription in telehealth patients and providers. Please let me know if I can clarify or provide any further information on this paramount concern.

Thanks,
Darin Willardsen, MD, MBA
CEO - Horizon Virtual
Internal Medicine Hospitalist
willardsend@horizonvirtual.net
C - [redacted]
W - (320) 345-5740

From: Bonnie Storbakken Lynette McDonald
Sent: Tuesday, December 18, 2018 8:59 AM
To: willardsend@horizonvirtual.net
Subject: Board of Medicine Meeting Highlights - November 2018

North Dakota Board of Medicine News Blast:
The Board of Medicine has filed an Agency Bill on Telemedicine for consideration at the 2019 Legislative [redacted]Session. The Telemedicine Bill attempts to put into law specific language regarding the practice of telemedicine in North Dakota. The Board discussed this at their November meeting and decided to submit the language that was proposed within the Administrative Rules Process. The language can be viewed by clicking here.
November 16, 2018 Board of Medicine Meeting Highlights:

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At the meeting the Board approved 193 physician licenses. Eight (8) stipulations for discipline were approved by the Board. The Board also approved seven (7) pharmacy collaborative agreements.

In addition, the Board listened to a presentation from Adam Peer from the American Association of Physician Assistants regarding the push for Physician Assistants across the nation to remove the supervision requirement for physician assistants. The Board was presented with a draft of language to amend the PA rule in North Dakota along with amendments to the language ensuring that PA's would be required to have two years of supervision after their training is complete and to ensure that PA's will not have the ability to own their own clinic. After the discussion the Board motioned to support this legislation as discussed if it were introduced in the upcoming legislative session.

The Board also listened to a presentation from the Federation of State Medical Boards (FSMB) regarding the services that are available to Boards through the Federation (www.fsmb.org). The FSMB representatives also provided information to the Board regarding the Interstate Medical Licensure Compact (IMLC). For more information on the IMLC, click here. The Board directed Bonnie to provide testimony in support of the IMLC if legislation is introduced in this upcoming legislative session.

As mentioned above, the Board discussed the telemedicine rule that had been passed and the direction from the Administrative Rules Committee to address this type of rule with the full body of the Legislature through an agency bill. The Board voted to have their Executive Secretary draft the Telemedicine Bill using the same language that was proposed to the Legislative Rules Committee.

2019 North Dakota Board of Medicine Meetings:

March 22, 2019
July 19, 2019
November 22, 2019

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But maybe they can change it ahead of time.

Courtney

[redacted]

Courtney Koebele | Executive Director| North Dakota Medical Association
1622 E. Interstate Ave. | Bismarck, North Dakota 58503
[redacted] | 701.223.9476 | ckoebele@ndmed.com | www.ndmed.org

From: Sens, Mary <mary.sens@und.edu>
Sent: Tuesday, December 18, 2018 12:18 PM
To: lmcdonald@ndbom.org; Courtney Koebele <courtney@ndmed.com>
Cc: Barry Ziman (s) [redacted]>
Subject: Telemedicine Bill

Thank you for forwarding the proposed Telemedicine bill by the NDBOM for the upcoming legislative session. Please consider an amendment for specialty consultation. Although the "24 hour" exemption covers many consultations; some, including pathology and some oncologic or complex clinical consultations, may require more time and/or review of information. The proposed amendment below would cover this and serve our North Dakota patients while being totally congruent with the spirit and intent of the legislation.

Proposed Amendment Section 2:

[redacted]

(5) An intra-specialty clinical consultation for diagnosis of a patient in this state, provided that both specialists are trained in the same specialty and the specialist requesting the consultation is a physician licensed to practice medicine in the state.

I am happy to contact the proposed sponsors of this bill if needed. I have copied Courtney as a courtesy as well as Barry Ziman from the College of American Pathologists who is aware of other model legislation and is available to assist as needed. Although this proposed amendment would cover pathology consultations, it is much broader and would include any intra-specialty clinical consultation appropriate and needed for care of North Dakota patients.

Thank you,
Mary Ann

Mary Ann Sens, MD, PhD
Professor and Chair of Pathology
University of North Dakota
School of Medicine and Health Sciences
1301 N Columbia Road
Mailstop 9037 Room W424
Grand Forks, ND 58202-9037

Department Voice: 701-777-2561
Forensic main number: 701-777-1200
Departmental Fax: 701-777-3108
Direct voicemail: 701-777-2630

mary.sens@ndus.edu

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Bonnie Storbakken

From: Lynette McDonald
Sent: Monday, January 7, 2019 1:32 PM
To: Bonnie Storbakken
Subject: FW: 2019 Legislative Update: Physician Assistant & Telemedicine Bills

FYI

From: richard davis hart <[redacted]
Sent: Saturday, January 5, 2019 8:12 AM
To: Lynette McDonald <LMcDonald@ndbom.org>
Subject: Re: 2019 Legislative Update: Physician Assistant & Telemedicine Bills

Strongly support telemedicine bill. Medical costs can be reduced by technological advances. There are many patients I see who are chronically ill. They could be treated over phone. Unfortunately They clog up a surgical practice where we have real acute problems and not enuf time to take care of these patients and end up working at nite where costs are higher. Chronic fatigue contributes to Doctor burnout problems I know I haven't addressed all the reasons to support this advance but hopefully gave u some new perspectives. Dr. Richard Hart DO FACOS

Sent from my iPhone

On Jan 4, 2019, at 3:36 PM, Bonnie Storbakken <lmcdonald@ndbom.org> wrote:

> LEGISLATIVE UPDATE:
>
> The telemedicine bill will be heard by the Senate Human Services Committee on Wednesday, January 9, 2019 at 9:00 am CT.
>
> The Physician Assistant bill draft was provided to us. It has not received a number or committee assignment at this point but that should be taking place very soon.

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Bonnie Storbakken

From: Courtney Koebele <courtney@ndmed.com>
Sent: Monday, January 7, 2019 12:42 PM
To: Bonnie Storbakken
Subject: Fwd: S.B. 2094: Explanation of the Reasons for Replacing "Deemed"

Courtney Koebele
NDMA
[redacted]

Sent by iphone

From: Michael Mullen Sr. <[redacted]
Sent: Monday, January 7, 2019 12:14:10 PM
To: Courtney Koebele
Subject: S.B. 2094: Explanation of the Reasons for Replacing "Deemed"

Courtney Koebele, Executive Director NDMA
Dear Courtney:
I'm sure the last thing you need late on Monday morning are unsolicited comments from a persnickety curmudgeon on a bill you didn't draft.

I'm referring to S.B. 2094 relating to the practice of telemedicine, which was introduced at the request of the North Dakota Board of Medicine.

This bill contains an inappropriate word, "***deemed***," which in my view should not be used in legislation—even though to my surprise it is not included in a list of words to be avoided in the North Dakota Legislative Drafting Manual. *See* NORTH DAKOTA LEGISLATIVE DRAFTING MANUAL 2019 at 100-101 (the list of words and phrases to avoid using does not include "deem").

To cut to the chase, here is how, in my view at least, S.B. 2094 should be amended:

On page 2, replace line 20 with the following [not in formal amendment style, but showing changes]:

"The practice of medicine is ~~deemed~~ *considered* to occur in the state *where* the patient is located. A practitioner"

More formally the amendments I suggest would be as follows:

On page 2, line 20, replace "deemed" with "considered" and after "state" insert "where"

On page 3, line 24, replace "deemed" with "considered"

On page 4, line 1, replace "deemed" with "considered"

Explanation of the Reasons for Replacing Deemed

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The word deemed should be used only if a statute is creating a real legal fiction: treating a thing as something which in the real world it is not—e.g., "for the purposes of this act, a dog is deemed to be a horse."

As used in S.B. 2094, it is not clear that the practice of telemedicine doesn't "occur in the state where the patient is located[,]" North Dakota.

If the drafter of S.B. 2094 insisted on using the word *deemed* to describe a legal fiction, the bill might contain a sentence like this:
"A licensee practicing telemedicine shall be **deemed** to be located in
this state regardless of where the licensee is actually located when practicing telemedicine." *See* Bryan A. Garner, A Dictionary of Modern Legal Usage 254 (2nd ed. 1995) ("[deem] is a FORMAL WORD often used in legislation to create legal FICTIONS").

But "deemed" is not used in the legal fiction sense in S.B. 2094, so it should be replaced with "considered."

The ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT in describing *where* the practice of medicine *occurs* avoids the use of the term "deemed":

"For the purpose of the medical practice act, the practice of medicine is *determined to occur where the patient is located* in order that the full resources of the state are available for the protection of that patient." [Emphasis added.]

See ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT, Section II[C] (Definitions) (Adopted as policy by the Federation of State Medical Boards in April 2015), found at: http://www.fsmb.org/siteassets/advocacy/policies/essentials-of-a-state-medical-and-osteopathic-practice-act.pdf [last viewed Jan. 6, 2019].

As a famous 20th Century author of textbooks and teaching materials on legal and legislative drafting Reed Dickerson advised:

Don't say
Say
deem
consider

The Fundamentals of Legal Drafting by Reed Dickerson 127 (1965); *see also* Montana Bill Drafting Manual 2008, § 2-20, at 24 (same); South Dakota Guide to Legislative Drafting 29 (Rev. 2016) (same); *DRAFTING STYLE MANUAL, Alabama Legislative Drafting Service, Rule 7(h) ("Do not use 'deem' for 'consider.' Use 'deem' only to state that something is to be treated as true even if contrary to fact");* MASSACHUSETTS SENATE LEGISLATIVE DRAFTING AND LEGAL MANUAL, Part I.A.8. (3rd ed. 2003) ("Do not use 'deem' for 'consider'."); Legislative Drafting Style Manual - Utah Legislature, § __ ¶ xii ("A legislative drafter should avoid the word 'deem.' The term 'consider' is generally the appropriate term").

As Matthew Salzwedel a blogger on legal writing noted:

"Deem comes from Old English, and few non-lawyers use it. To take the example of Joe and his grocery shopping [ ], you probably won't hear him say that he "*deems* his grocery store to be the best store in town." Some lawyers, though, use *deem* to create a legal fiction, as in "*the parties deem that they entered into this contract on January 1, 2014*." This usage is minimally defensible." Matthew Salzwedel, on Faux Words of Precision—Part 1 (Sept. 4, 2013), found at: https://lawyerist.com/faux-words-precision-part-1/ (in 2012 Salzwedel created a site the *Legal Writing Editor*)

And, as Bryan Garner notes in Garner's Modern American Usage, (3rd ed. 2009), *deem* "is a formal word that imparts the flavor of archaism. It frequently displaces a more down-to-earth term such as *consider, think, or judge*." Generally speaking, "no precision is gained from using *deem* in its archaic sense. No judge will penalize a lawyer who uses the *parties consider* or *the parties agree* in its place."

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I hope you appreciate receiving unsolicited advice on arcane issues.

Best wishes,
Mike

PS—This is how I killed some time on Sunday after snowboarding and before the NFL playoff games. And, after collecting the information I thought I've got to send it to somebody.

#1

North Dakota Board of Medicine

Established 1890

418 E Broadway Ave, Suite 12 • Bismarck, ND 58501-4086
Phone (701) 328-6500 • Fax (701) 328-6505
www.ndbom.org

Bonnie Storbakken
Executive Secretary

Lynette McDonald
Deputy Executive Secretary

SB 2094
3-25-19

March 21-2019

Chairman Weisz and members of the House Human Services Committee,

I would like to provide testimony regarding Engrossed Senate Bill 2094 concerning telemedicine. To briefly introduce myself, I am the current chairman of the North Dakota Board of Medicine as well as the Program Director of UND School of Medicine's Psychiatry Residency. I was raised in Williston, graduated from Jamestown College and UND Medical School which included rotations in Grand Forks, Minot, Garrison and Williston. I completed my Psychiatry training in Oregon and the past 30 yrs have been a practicing Adult and Geriatric Psychiatrist in Fargo. I spent 10yrs doing weekly outreach to Valley City. I have been heavily involved with the education and training of medical students and residents throughout my career.

Four years ago, as the new residency director, we approached UND regarding expansion of the residency to address the severe shortages of mental health treatment in our state. A key component of the proposal was rural outreach and telemedicine. We are now completing our fourth year of this expansion from 16 to 24 total psychiatry residents and have all of our 3rd and 4th year residents actively doing telemedicine. This includes regular outreach and weekly telemedicine to: Williston, Minot, New Town, Dickinson, Bismarck (2 sites), Devil's Lake, Grand Forks, Jamestown and Valley City. We believe strongly that this telemedicine outreach is impacting the region and also providing our residents with the crucial training and opportunity to become expert with this technology.

Specifically, I would like to speak to the important issue of the video component of telemedicine. We require this in our training and feel this is crucial to establishing doctor-patient relationships as well as providing important information to the physician. Early in residency training our residents learn how to interview and communicate with their patients. This includes active listening skills, report building, eye contact and paying attention to body language (both that of the patient as well as the young doctors). Components of our examinations include the patient's appearance, the steadiness of their walk (gait), patterns of unusual movements like tremors, eye movements. Clues like bruises, lacerations, sweatiness, being unkempt can only be seen in person or through video.

I would like you think of several circumstances to illustrate the power of our eyes in combination with our ears:

Mission Statement
The Board's mission is to protect the public's health, safety and welfare by regulating the practice of medicine, thereby ensuring quality health care for the citizens of this state.

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As a grandparent, think of the difference when you can see and communicate with your young grandchild by FaceTime, skype or some other live video experience vs audio only phone call. You learn so much more, your pleasure is enhanced, the power of connection…how real you are to that grandchild…by the video addition.

I am old, I still love radio, but there is no question about the difference in immersion in a movie or sporting event when you see and hear it on a big screen vs audio only.

If you think about what makes the best doctor experience, I believe it is when we feel understood and that the doctor takes time for us, is truly interested in helping us, has expressed empathy with our troubles and helps with a plan of action. Good bedside manner includes eye contact, body language of attending to our concerns, showing concern on their face. They can see our distress, our tears, our pain. Now take that same doctor, coming into your hospital or clinic exam room, and have the nurse pull the curtain before they enter so the entire meeting is verbal only, through the curtain. Can it be the same? Can the patient-doctor relationship be as good? Can the patient feel as understood and can the doctor pick up the important clues? I don't believe so, but good quality video/audio can come very close.

The quality of the contact goes beyond just patient satisfaction, patients actually improve more when the relationship is stronger. I am a proponent of telemedicine; my residents are immersed in it with their training. I hope this testimony helps you understand why I feel the video component is so important, especially for the initial meeting. In psychiatry, in particular, I believe it is crucial to all of our contacts. I support, Engrossed Senate Bill 2094, with the amendment proposed by Bonnie Storbakken.

Thank you for your time.

Robert Olson MD

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3-25-19

UNIVERSITY OF NORTH DAKOTA

UND.edu

SCHOOL OF MEDICINE AND HEALTH SCIENCES

Department of Surgery
1301 N Columbia Rd, Stop 9037
Grand Forks, ND 58202-9037
Phone: (701) 777-3069
Fax: (701) 777-2609
www.med.und.edu/surgery

March 22, 2019

Human Services Committee
Sixty-sixth Legislative Assembly of North Dakota
Bismarck, North Dakota

Chairman Weisz and Honorary Committee Members,

As a practicing physician in the State of North Dakota and member of the North Dakota Board of Medicine I would like to give my support for the Telemedicine Bill (Engrossed SB 2094) with the amendments proposed by Bonnie Storbakken, Executive Secretary of the Board of Medicine. With current technology and the near universal availability of smart phones and video conferencing this service would be of great benefit to the citizens of North Dakota, especially in the rural areas which require significant travel distances for in person visits and can be affected by our sometimes unpredictable weather conditions.

I am aware that there has been discussion and debate on the value and necessity of an initial videoconference telemedicine visit to establish a physician patient relationship. I strongly believe that an initial videoconference is necessary for several reasons, not the least being patient safety. In my opinion it is difficult, if not impossible, to safely identify and establish a confidential physician patient relationship without both the physician and patient seeing each other on the initial visit. I feel that this must be present for the ethical practice of medicine and certainly would help patients to be comfortable and confident with the provider they are establishing the relationship with. The potential for abuse and error is significantly higher without this necessary first step in the provider patient relationship. It is highly unlikely that this requirement would be prohibitive as it is rare that I encounter a patient who does not have a smart phone with video capabilities and we have very good mobile coverage across our state.

I thank the committee for their work in the healthcare field which will help to improve the lives and health of the citizens of North Dakota. If I can provide any other information or be of assistance please do not hesitate to contact me.

Robert P. Sticca, MD, FACS

Professor and Chairman, Program Director
Department of Surgery, Suite E270
University of North Dakota School of Medicine & Health Sciences
1301 North Columbia Road, Stop 9037
Grand Forks, ND 58202-9037.

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HISTORICAL DOCUMENTS

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Administrative Rules Committee
December 5, 2017

North Dakota Board of Medicine
Bonnie Storbakken, Executive Secretary

Chairman Devlin, members of the Administrative Rules Committee, my name is Bonnie Storbakken I'm executive secretary of the North Dakota Board of Medicine. Thank you for the opportunity to provide testimony regarding rules recently passed by our board.

Please accept the following responses to the questions outlined in the letter I received from Vonette Richter.

1. These rules are not the result of statutory changes made by assembly, except for the PDMP rule which was required to be implemented in 2015 legislation introduced by Representative Kaiser in HB 1149 which required licensing Boards to implement rules regarding participation in the PDMP.

2. These rules are not related to any federal statute or regulation.

3. We followed the rule making procedure as outlined in state law and summarized in the Attorney General's manual for state agencies. Specifically, we published written notice of intent to adopt these rules in all legal newspapers during the week of August 30, 2017. We held public hearing on the rules in our office on Wednesday, September 27, 2017. We held the record open for the required 10 days following the hearing for written and oral comments. The board had a meeting in October to discuss and consider the comments. Process was reviewed by the Attorney General and approved as to its Legality in an opinion dated October 27, 2017.

4. Oral comments were received at the hearing held in September from Teledoc, Sanford Health as well as Dr. Andy McLean. These comments were regarding the telemedicine rule. Oral comments were received from the Attorney General's office that were confirmed through email regarding the PDMP rule. And written comments were received on both the PDMP rule as well as the telemedicine rule. All comments were included within Packet 1 that was sent to the Legislative Council. Additionally, all comments received on the telemedicine rule from the 2015 rulemaking process were also submitted.

5. The major cost of developing and adopting these rules other than staff time was the cost of publication which was $ 2,239.44 for this publication and $2,052.84 for the previous publication done in 2015 which was done for the telemedicine rule only.

6. A brief explanation of each rule and what prompted the rule is included at the end of this testimony.

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7. A regulatory analysis was done regarding the telemedicine rule. The result of the regulatory analysis was that it was impossible to calculate the impact of this rule.

8. No small entity analysis was made as the board is exempt.

9. The rules have no fiscal effect.

10. No taking's assessment was required.

11. These rules were not adopted as emergency or interim rules.

Number 6: Brief description of each rule and the reason for enacting each rule.

50-02-02-01 Exceptions to technical requirements on licensure.
This rule was passed by the board after receiving applications from numerous applicants that were just slightly outside of the board's technical requirements to obtain licensure in the state of North Dakota. The board wanted to ensure the ability to license folks who are board-certified and would provide a unique or special contribution to the practice of medicine not readily available elsewhere within the state of North Dakota.

50-02-02.1 The Administrative License
This license was developed when reviewing applicants who had spent the majority of their time in administrative functions and wanted to continue to provide those services but hadn't practiced in some time. The license allows for the administrative function to continue but not allowing patient care. This license is one that has been utilized in other states as well.

50-01-15 Telemedicine
The telemedicine rule attempts to define the practice of telemedicine within the state ensuring that there is a standard of care that must be adhered to and defining how that standard of care is met. The board has been contemplating the rule on telemedicine since prior to 2015. In 2015 the Board approved this draft to move forward through the rule making process. The Board did hold a public meeting and hearing on this rule in 2015 and that process was not approved by the Attorney General's office for lack of proper notice.

The rule has not changed outside of minor corrections in numbering and grammar since it was noticed and reviewed in 2015. The summary of the comments received in 2015 as well as the summary of comments received in 2017 is attached for your review. Some of the comments remain the same and others are new.

In 2015 and in 2017 Teledoc requested less technology specific language seeking the use of a phone call with store and forward technology. The board has received and reviewed these comments twice now and remains dedicated to the current language which requires a like in-person meeting when establishing the licensee-patient relationship. There are a few reasons

that have been discussed by the Board to keep this language. The intent of the Board is to ensure that the standard of care is no different in an in person meeting with your provider than it would be through a telemedicine meeting. If the standard of care would require the provider to look into the patient's ear with an otoscope then that would be expected to be conducted through a telemedicine visit as well using technology and peripherals as necessary. The language in the rule allows for the provider to use their discretion in how to conduct future meetings with an established patient specifically, to allow proper follow up care. Again, the overall intent is to ensure that the standard of care is met for each patient interaction.

Another important issue the Board considered is the responsible stewardship of antibiotics. This discussion has not gone away since the original inception of creating this rule it has only become more emergent. I have also included a Power Point on this subject from Dr. Paul Carson within your materials.

One of the comments that was received by the North Dakota Psychiatric Society was a new comment that was not made in 2015. This comment had to do with our prohibition of opioid prescribing through a telemedicine encounter. The Psychiatric Society has asked that an exception be made for medications used in Medication Assisted Treatment (MAT) such as buprenorphine. Although there was some support for this on the Board it was the decision of the Board not to create this exception. The medication referred to although it can treat opioid addiction it also has the potential to be abused, misused and diverted.

50-05-02 Prescription Drug Monitoring Program
This rule requires every practitioner with a DEA registration number to register with the prescription drug monitoring program and further defines how the prescription drug monitoring program should be utilized within their practice. This rule was based on action taken by the legislature in 2015. HB 1149 introduced by Representative Kaiser required all regulatory boards to require licensed individuals under the boards jurisdiction who prescribe or dispense controlled substances to utilize the prescription drug monitoring program.

I would be glad to try to answer any questions of the committee.
Respectfully submitted,

Bonnie Storbakken
Executive Secretary
North Dakota Board of Medicine

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REGULATORY ANALYSIS

Proposed rule chapter 50-02-15, Telemedicine

The North Dakota Board of Medicine has proposed five administrative rules for hearing on September 26, 2017: one dealing with telemedicine, one dealing with administrative licenses, one dealing with special licenses, one dealing with the Physician Drug Monitoring Program (PDMP) and one dealing with the supervising physician for physician assistants. Only the proposed rule dealing with telemedicine requires a regulatory analysis.

The proposed telemedicine rule may have an impact on the regulated community in excess of fifty thousand dollars, although, for the reasons stated, it is not possible to quantify the amount of impact.

1. **Affected classes.** Physicians and physician assistants who wish to practice telemedicine will be affected by the proposed rule. There are no direct costs associated with the rule.

2. **Impact of the rule.** The rule permits the establishment of a patient-physician relationship through acceptable encounters and evaluations that occur with the patient in one location and the practitioner in another. It allows diagnoses and subsequent treatments, with the exception of prescribing opioids for pain management, based on such a telemedicine encounter. This will have a large impact on the regulated community with respect to how they may choose to deliver medical services. It will have a large impact on North Dakota citizens in terms of how they choose to obtain medical care.

The rule specifically excludes the establishment of a patient-physician relationship made only over the telephone or through a static online questionnaire as acceptable forms of telemedicine.

It is not possible to determine the positive economic impact for North Dakota licensed physicians -- who may or may not physically reside in North Dakota – who diagnose and treat patients using approved telemedicine. Nor is it possible to determine the negative economic impact for those North Dakota licensed physicians working for a telemedicine company that chooses to utilize a method of telemedicine that is not acceptable under the rule, that is, telephone or online questionnaire only.

3. **Quantification of data.** It is not practicable to attempt to quantify the impact of the rule. It is dependent on an unknown number of encounters between North Dakota licensed physicians, over half of whom physically practice out of state, and North Dakota citizens. The field of telemedicine is changing rapidly, from more traditional forms, such as remotely reading radiology films, to direct-to-consumer primary care. The nature and costs associated with this type of care cannot be accurately predicted.

4. **Costs and revenues.** There will be a cost of approximately $2,200.00 to implement the rule, primarily for publication costs. There are no other implementation costs. Nor are there identifiable enforcement costs.

5. **Consideration of alternate methods of regulating telemedicine.** The Board studied this issue for over a year and considered key alternatives to this rule. It published proposed policies on its website and requested comments from all licensees and the public regarding the appropriate regulation of telemedicine. It received numerous comments which informed the content of this rule. A list of those submitting comments, as well as the comments themselves, are available.

The board seriously considered many alternatives to the proposed rule, including the requirement of having an intervening health care provider at the site of patient during a remote encounter; regulating the technology required for acceptable telemedicine encounters; prohibiting the prescribing of all controlled substances through a telemedicine encounter; requiring the automatic provision of medical records to telemedicine patients; allowing telephone-only encounters or encounters based only on online questionnaires; allowing video encounters without the use of diagnostic tests or peripherals to be acceptable.

In the end, the board decided to impose a rule stating telemedicine rules must be the equivalent of an in-person evaluation or examination, and use the lab tests and peripheral tools that would be used in an in-person encounter. Diagnosis and treatment could then be done in the practitioner's discretion. It was felt this allowed the benefits of telemedicine to be enjoyed by North Dakota citizens while maintaining a standard of care equivalent to that required of more traditional medical encounters. The one exception was the prohibition of prescribing opioids for pain control through telemedicine, which was done to avoid exacerbating the prescription drug diversion and abuse epidemic currently facing the state and country.

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Summary of oral comments received at the public hearing for proposed rules of the North Dakota Board of Medicine

The public meeting was opened at 9:00 am by Bonnie Storbakken the executive Secretary for the North Dakota Board of Medicine. Nine people attended the hearing, they are listed as follows:

1. Dr. Jason Tibbles representing Teledoc
2. Claudia Tucker representing Teledoc
3. John Ward from Zueger Kermis and Smith representing Teledoc
4. Marnie Walth representing Sanford Health
5. Dr. Chris Meeker representing Sanford Health
6. Dr. Andy McLean representing North Dakota Department of Human Services and UND SM HS
7. Courtney Koeble representing the North Dakota Medical Association
8. Megan Houn representing Blue Cross and Blue Shield of North Dakota
9. Luis San Jose representing himself.

Telemedicine Rule Comments:

1. The comments received from Dr. Andy Mclean were regarding the prescribing section of the telemedicine rule. Dr. McLean states that the section regarding the prescription of opioids may have impact on treatment of opioid use disorders. As such, Dr. McLean suggested an exception to this section for prescribing done for medical assisted treatment. Dr. McLean also provided a written comment reiterating his analysis of the rule.
2. The comments received from the Teledoc representatives stated that they also provided a written comment in the form of a letter but wanted to appear in person to listen and participate in the hearing. The comments from Teledoc were related to the requirement of the use of audio visual in the development of a patient-licensee relationship. They stated that taking care of patients without video is done every day and that patients should have a choice in how they engage in their medical care. They suggested that the use of the standard of care language and less technology specific language would be better as innovation will always outrun technology. Removing the technology specific language would provide for more access as not all folks in North Dakota are in a place that has broad band internet.
3. The representatives from Sanford also centered on the development of the licensee-patient relationship. They stated that this relationship should be established by at least one face to face meeting or an initial video visit. This may allow the physician to uncover more of what is happening with the patient. There is a potential for misdiagnosis due to a lack of information.

No other comments were received at the hearing.

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Summary of Written Comments received on the 2017 Rules Package.
2017

Telemedicine Rule:

Teledoc seeking changes regarding the requirement of a like in person examination specifically, the video requirement.

Sanford Health comments involve changing the language regarding the development of a valid patient relationship. There was support for a like in person examination from Sanford. Specifically, they used two way video or in person examination to establish the patient relationship within their recommended language.

Allergy and Asthma Network objected to the requirement of the use of audio visual technology to establish a patient licensee relationship.

New Benefits who asked for technology neutral language eliminating the requirement for audio visual technology to establish the physician patient relationship.

United Spinal Association who asked for elimination of the requirement of the use of video in establishing the physician patient relationship.

Dr. Andrew McLean seeking an exception for prescribing of buprenorphine products when used for MAT purposes.

North Dakota Psychiatric Society whose comments were seeking an exemption for prescriptions of medication used for medication assisted treatment (MAT).

Dr. Laura Lizakowski objecting to the prohibition of prescription of opiates via telemedicine based on her practice of palliative medicine and management of pain patients with metastatic cancers.

PDMP Comments

Sanford Health seeking to eliminate language from section 3 of the PDMP rule specifically the list of signs that would require the provider to check the PDMP and allowing for more general language to precipitate the requirement for checking the PDMP.

Attorney General

Seeking to add additional items to the list of signs requiring a practitioner to check at the PDMP based on the fact that they would be things readily noticeable by the physician.

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Paul Azure

Objecting to the requirement to report prescriptions to the PDMP based on health care cost.

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TELADOC.

September 20, 2017

Bonnie Storbakken
Executive Secretary
North Dakota Board of Medicine
418 East Broadway, Suite 12
Bismarck, ND 58501

Re: Proposed Rules Relating to Telemedicine Services

Dear Ms. Storbakken:

Teladoc appreciates this opportunity to comment on the North Dakota Board of Medicine proposed rules relating to Telemedicine Services. Telemedicine is dynamic and evolving. Teladoc respects the role of the Board in considering the appropriate rules and clinical practice guidelines that are designed to be protective of public health and maintain high-quality care for patients while permissive of new technological innovations.

Teladoc is the nation's first and largest telehealth platform, delivering on-demand healthcare anytime, anywhere, via mobile devices, a web-based portal, video and interactive audio. We connect our enrollees with our network of more than 3100 board-certified physicians and mental health providers with an average of 15 years of physician experience. These physicians treat a wide range of conditions such as upper respiratory infection, urinary tract infection, influenza and sinusitis. Over 20.1 million enrollees now benefit from access to Teladoc 24 hours a day, seven days a week, 365 days a year. After more than a decade of service and over 2.5 million telehealth visits, Teladoc has yet to be subject to a single malpractice claim. With over 100 proprietary clinical guidelines, NCQA certification and our recent HITRUST certification, nothing is more important to Teladoc than quality health care.

Teladoc telehealth delivery model

Teladoc provides telemedicine services via web-based interactive audio-video visits or interactive audio using asynchronous store and forward technology, as selected by the patient. Teladoc physicians only treat minor, non-emergent, non-recurring medical issues with short-term prescriptions of common medications as may be appropriate to the diagnosis and standard of care. Teladoc physicians, where appropriate, advise the patient regarding whether that patient should seek an in-person consultation with a physician or go to an emergency room. The Teladoc physician may also refer the patient back to his or her primary care physician when appropriate.

Teladoc' s services are only provided to patients through their employer, health-insurance company, state Medicaid plan or hospital system and are not open to the direct-to-consumer market. Only patients who have been appropriately validated through the Teladoc system may make appointments for a telehealth visit with Teladoc physicians.

Prior to a telehealth visit, the patient is required to complete a thorough medical history, including an overview of his or her care, allergies, medications, lab tests, family history, and the name of the

Teladoc 2 Manhattanville Road, Suite 203 + Purchase, NY 10577
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patient's primary care physician if he/she has one. The patient is then placed in the queue to receive a telehealth visit. There is less than 10 minutes median physician response time. A Teladoc physician licensed in the state where the patient is located must access the patient's medical history/electronic health record and review it prior to being given the patient's contact information to initiate the telehealth visit. The physician verifies the patient's identity, makes appropriate documentation in the patient's medical record, acquires the patient consent to diagnose and treat, establishes a diagnosis, and recommends treatment (where appropriate), all in accordance with the appropriate standard of care.

During a telehealth visit, an array of medical technology is available to appropriately address the patient's concerns. This includes the ability to have a secure videoconference as well as upload medical images and files in real time. The Teladoc electronic platform also allows for easy follow-up contact by the patient or physician at any point, and Teladoc physicians are authorized with patient consent to communicate with the patient's primary care physician whenever necessary or appropriate to ensure continuity of care. The patient's electronic health record ("EHR") is updated after each consultation, is easily accessible to the patient on an ongoing basis, and will be provided to the patient's physicians (including the primary care physician) with the patient's permission.

Significantly, Teladoc physicians do not prescribe DEA-controlled substances, non-therapeutic drugs, lifestyle drugs and certain other drugs which may be harmful because of their potential for abuse.

For emergencies, patients are told to immediately visit their local emergency room, call 911 or our physicians will make the call for the patient.

North Dakota Board of Medicine proposed rule 50-02-15

Teladoc applauds the Board's recognition that telemedicine is a valuable tool that uses technology and innovation to improve access to quality healthcare to the citizens of North Dakota. As the Board contemplates good public policy that removes barriers to access, it is important to note that the standard of care should be the same for telemedicine as it is for traditional in-person medicine. Physicians should use their professional judgement as to whether a telemedicine visit is appropriate and what technology is needed in order to establish a valid physician-patient relationship. Using the standard of care requirement, it is important that the Board use "technology neutral" language. As we know, technology advances are much faster than either the legislative or regulatory processes. As noted in HB 1038 which passed in the 2015 legislature, coverage for telehealth services included such technology neutral language; I cite that portion of the bill below:

> g. "Telehealth":
> (1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site; and that is delivered over a secure connection that complies with the requirements of state and federal laws.

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Accordingly, we submit the following recommendations to 50-02-05-03 that track with best practices on telemedicine policy throughout the country:

> c) Evaluations and examinations required to establish a patient-license relationship. Prior to initially diagnosing or treating a patient for a specific illness or condition, an examination or evaluation must be performed. An examination or evaluation may be performed entirely through telemedicine, if the examination or evaluation is equivalent to an in-person examination. A video examination that utilizes appropriate diagnostic testing and use of peripherals that would be deemed necessary in a like in-person examination or evaluation would meet this standard, the use of interactive audio with asynchronous store and forward technology or audio-video, at the professional discretion of the physician, would meet this standard as would an examination conducted with an appropriately licensed intervening health care provider, practicing with the scope of their profession, providing necessary physical findings to the licensee. An examination or evaluation that consists only of a static online questionnaire or an audio conversation "in isolation" will not be considered to meet the standard of care.

We believe that the citizens of North Dakota should not be disenfranchised from access to affordable, quality healthcare just because they do not have access to broadband internet (needed for audio-video) or do not have a smartphone/computer or who do not have the capability to navigate through a web-based platform. We believe that the best technology should be made available to the patient, but the patient should have the right to choose how he/she accesses the telehealth visit with the physician's discretion.

Nationally, 62 million Americans do not have a primary care provider and we expect a 131,000 physician shortage by 2025. Eighty percent of ER visits are due to a lack of access to primary care. Telemedicine is a tool that will address the access to care issue, along with providing the citizens and businesses of North Dakota a way to decrease their costs for a doctor's visit to treat a simple non-emergent illness.

Thank you again for this opportunity to comment and for your kind consideration.

Sincerely,

Claudia Duck Tucker
Vice President, Government Affairs
Teladoc

cc: Dr. Jason Tibbels, Senior Medical Director, Teladoc
Adam Vandervoort, Chief Legal Officer, Teladoc

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Lynette McDonald

Subject: FW: Rule Comments

From: McLean, Andrew J. [mailto:ajmclean@nd.gov]
Sent: Wednesday, September 27, 2017 10:50 AM
To: Lynette McDonald <LMcDonald@ndbom.org>
Subject: Re: Rule Comments

Hey, Lynette,
Here were my comments to the ND telehealth workgroup. If you need something more formal from me, let me know.
Andy
p.s. at end of week, work e-mail address: andrew.mclean@med.und.edu

50-02-15-04. **Prescribing.** A licensee who has performed a telemedicine examination or evaluation meeting the requirements of this chapter may prescribe medications according to the licensee's professional discretion and judgment, with one exception: Licensees may not prescribe opioids through a telemedicine encounter.

"Issue: This is more restrictive than Federal rules, in that controlled substances may be prescribed via telemedicine by a physician or physician assistant if an in-person evaluation of the patient has been performed by that provider. While caution needs to be taken in the prescribing of controlled substances, limiting an entire class of medication may place an undue burden on individuals, particularly those in rural areas who require medication assisted treatment (MAT) for opioid use disorders.

The recommendation would be to allow telemedicine prescribing of buprenorphine products when used for MAT purposes."

Sent from my iPhone

On Sep 27, 2017, at 10:06 AM, Lynette McDonald <LMcDonald@ndbom.org> wrote:

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SANFORD HEALTH

DELIVERED VIA EMAIL

October 9, 2017

Ms. Bonnie Storbakken
Executive Secretary
North Dakota Board of Medicine
418 E Broadway Ave, Suite 12
Bismarck, ND 58501

RE: North Dakota Board of Medicine Notice of Intent, dated August 24, 2017, TO ENACT ADMINISTRATIVE RULES RELATING TO THE PRACTICE OF TELEMEDICINE AND TO THE ISSUANCE OF ADMINISTRATIVE MEDICAL LICENSES, AND TO ENACT ADMINISTRATIVE RULES RELATING TO PDMP REPORTING REQUIREMENTS, AND TO AMEND AN ADMINISTRATIVE RULE RELATING TO SPECIAL MEDICAL LICENSES, AND TO AMEND ADMINISTRATIVE RULES RELATING TO THE SUPERVISING PHYSICIAN FOR PHYSICIAN ASSISTANTS.

Dear Ms. Storbakken:

Sanford Health respectfully submits this comment in response to the above-referenced notice. We appreciate the opportunity to offer our perspectives on these proposed changes and outline how they might impact the patients we serve across North Dakota. These comments may be supplemented or amended as we gain further understanding of the issues.

1. **Enactment of 50-02-15-01, NDAC, relating to the practice of telemedicine**

   As communicated to your predecessor, Mr. Houdek, Sanford shares the board's concerns for quality preservation as telemedicine becomes increasingly prominent in the delivery of care. It is Sanford's position that the proposed rule provide adequate flexibility to accommodate emerging technology-based care delivery systems and the capable medical judgment of this board's licensees. Accordingly, Sanford urges modifications to the proposed rule that:

   - Define a "valid patient relationship" as one established through meaningful in-person or two-way video engagement;

SANFORD HEALTH

- Give greater weight to the medical judgment of providers and the ethical standards to which they are held; and

- Within the context of a valid patient relationship, allow providers the professional latitude to deploy a full range of technological resources in a manner that still satisfies applicable medical standards of care.

Attached for your consideration as *Appendix I* is a redlined version of the proposed rule intended to capture the themes described above.

2. **Enactment of 50-02-02.1, NDAC, relating to the issuance of administrative medical licenses**

At this time, Sanford does not wish to offer comments on this rule.

3. **Amendment to 50-02-02-01, NDAC, relating to special license requirements**

At this time, Sanford does not wish to offer comments on this rule.

4. **Enactment of 50-05-02, NDAC, relating to the PDMP**

Sanford fully supports the promulgation of rules to thoughtfully address the serious issue of opioid abuse in North Dakota. Such efforts are consistent with Sanford's own proactive policies and educational initiatives, which continue to yield encouraging results.

As a dedicated partner in this effort, Sanford urges consideration of the following modifications intended to produce a stronger, clearer, more practical rule:

- Strike and add language to Section 2. A. as follows:

  When a practitioner determines that reported drugs will be prescribed to a patient for a period to exceed 12 weeks, the practitioner, or his or her designee, shall request a PDMP report for that patient ~~and, at minimum, at least semi-annually thereafter~~.

  The purpose of the above change is to promote efficient delegation of PDMP access and to create a simpler, cleaner requirement for PDMP consultation. Elimination of the latter

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provision creates a clear instruction of PDMP access upon <u>every</u> prescription of reported drugs that exceeds 12 weeks.

- Strike and add language to Section 3 as follows:

  In addition to those reports requested under paragraph 2, practitioners ~~shall request a PDMP report when it is documented in the prescribing practitioner's medical record for that patient that the patient exhibits signs associated with diversion or abuse, including, but not limited to:~~ <u>prescribing reported drugs shall request a PDMP report when, upon examination of a patient, it is clinically apparent the patient is susceptible to diversion or abuse, or the prescribing practitioner's medical record for that patient reflects a readily discernible pattern of behavior suggesting the same.</u>

  ~~A. Selling prescription drugs;~~
  ~~B. Forging or altering a prescription;~~
  ~~C. Stealing or borrowing reported drugs;~~
  ~~D. Taking more than the prescribed dosage of any reported drug;~~
  ~~E. Having a drug screen that indicates the presence of additional or illicit drugs;~~
  ~~F. Being arrested, convicted or diverted by the criminal justice system for a drug-related offense;~~
  ~~G. Receiving reported drugs from providers not reported to the treating practitioner; and~~
  ~~H. Having a law enforcement or health professional express concern about the patient's use of drugs.~~

  The purpose of the above change is to more generally summarize the circumstances under which a practitioner should consult the PDMP, whether compelled by clinical observation or information discerned from a patient's medical record. This change places greater weight on a practitioner's medical judgment while still contemplating a wide range of factors. The laundry list of factors contained in the draft rule are not entirely applicable to or practically accessible within a patient's medical record.

- Strike Section 4.

  The purpose of the above change is to promote clinical efficiency. It is Sanford's understanding that the PDMP system itself logs practitioner usage and could be consulted in

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the event of a licensee investigation. Should the board see it appropriate to preserve this provision, Sanford recommends adding "or his or her designee" after the word "practitioner" for the same reasons stated under Section 2.A.

5. **Amendment to 50-03-01-03, NDAC, relating to the supervision contract requirements for physician assistants**

   At this time, Sanford does not wish to offer comments on this rule.

6. **Amendment to 54-03-01-05, NDAC, relating to the designation of a substitute primary supervising physician**

   At this time, Sanford does not wish to offer comments on this rule.

Thank you for the opportunity to offer comments. Sanford looks forward to working with you and the board to find the properly balanced approach to these important issues.

Sincerely,

Tim Rave,
Executive Director, Public Policy

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APPENDIX I

CHAPTER 50-02-15
TELEMEDICINE

50-02-15-01. Definitions. As used in this chapter,
"Telemedicine" means the practice of medicine using electronic communication, information technologies or other means between a licensee in one location and a patient in another location, with or without an intervening healthcare provider. It includes direct interactive patient encounters as well as asynchronous store-and-forward technologies and remote monitoring.

"Licensee" means a physician or physician assistant licensed to practice in North Dakota. A physician assistant practicing telemedicine from another state is subject to the rules regarding physician supervision, except that supervision may be by a North Dakota licensed physician who is practicing telemedicine in North Dakota from the same state as the physician assistant, and need not be by a North Dakota licensed physician who is physically located in North Dakota.

"Valid patient relationship" means a relationship between a patient and licensee that is established through an initial in-person or two-way video examination or evaluation. For purposes of this chapter, a valid patient relationship created between a patient and licensee extends to all licensees of the same practice group or call coverage group.

50-02-05-02. Licensure. The practice of medicine is deemed to occur in the state the patient is located. Practitioners providing medical care to patients located in North Dakota are subject to the licensing and disciplinary laws of North Dakota and must possess an active North Dakota license for their profession.

50-02-05-03. Standard of care and professional ethics. Licensees are held to the same standard of care and same ethical standards whether practicing traditional, in-person, medicine or telemedicine. Therefore, the following apply in the context of telemedicine:

a) Scope of practice. Professional ethical standards require all practitioners to practice only in areas in which they have demonstrated competence, based on their training, ability and experience. In assessing a licensee's compliance with this ethical requirement, consideration will be given to board certifications and specialty groups' telemedicine standards.

b) Patient-Licensee relationship. A licensee practicing telemedicine must establish a valid patient relationship ~~with the patient~~ prior to the diagnosis and/or treatment of a patient. A licensee practicing telemedicine shall verify the identity of the patient seeking care; and disclose, and ensure the patient has the ability to verify, the identity and licensure status of any licensee providing medical services to the patient.

c) Evaluations and examinations required to establish a patient-licensee relationship. Prior to initially diagnosing or treating a patient for a specific illness or condition, an examination or evaluation must be performed. An examination or evaluation may be performed entirely through telemedicine, so long as the use of telemedicine permits the licensee to obtain necessary patient information to evaluate, diagnose and treat the patient in a manner consistent with applicable medical standards of care. ~~if the examination or evaluation is equivalent to an in-person examination. A video examination that utilizes appropriate diagnostic testing and use of~~

~~peripherals that would be deemed necessary in a like in-person examination or evaluation would meet this standard, as would an examination conducted with an appropriately licensed intervening health care provider, practicing within the scope of their profession, providing necessary physical findings to the licensee.~~ An examination or evaluation that consists only of a static online questionnaire or an audio conversation will not be considered to meet the standard of care unless a valid patient relationship already exists.

Once a licensee conducts an acceptable examination or evaluation, whether in-person or by telemedicine, and establishes a ~~patient-licensee~~ valid patient relationship, subsequent follow-up care may be provided as deemed appropriate by the licensee, or by a provider designated by the licensee to act temporarily in the licensee's absence.

It is recognized that in certain types of telemedicine utilizing asynchronous store-and-forward technology or electronic monitoring, such as tele-radiology or ICU monitoring, it is not medically necessary for an independent examination of the patient to be performed.

d) Medical records. Licensees practicing telemedicine are subject to all North Dakota laws governing the adequacy of medical records and the provision of medical records to the patient and other medical providers treating the patient.

e) Licensees must have the ability to make appropriate referrals of patients not amenable to diagnosis or complete treatment through a telemedicine encounter, including those patients in need of emergent care, or complementary in-person care.

50-02-15-04. Prescribing. A licensee who has performed a telemedicine examination or evaluation meeting the requirements of this chapter may prescribe medications according to the licensee's professional discretion and judgment, with one exception: Licensees may not prescribe opioids through a telemedicine encounter.

Licensees who prescribe controlled substances, as defined by North Dakota law, in circumstances allowed under this rule, must comply with all state and federal laws regarding the prescribing of controlled substances, and must participate in the North Dakota Prescription Drug Monitoring Program.

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Lynette McDonald

From: Bonnie Storbakken
Sent: Friday, September 22, 2017 9:29 AM
To: Lynette McDonald
Subject: Fwd: proposed rule

Sent from my iPhone

Begin forwarded message:

From: LAURA LIZAKOWSKI <LLIZAKOWSKI@altru.org>
Date: September 22, 2017 at 9:03:21 AM CDT
To: "bstorbakken@ndbom.org" <bstorbakken@ndbom.org>
Subject: proposed rule

I am very concerned about the proposed rule to not allow providers to prescribe opiates via a telemedicine visit. I practice palliative medicine and manage pain of patients with metastatic cancers. Many of these patients are quite ill and weak and are in a lot of pain. Those long car rides can be quite difficult for them when they are having a lot of pain. It's really sad that we are now making blanket rules for all patients who are taking opiates. We've lost sight of compassion for who those patients who are suffering greatly and truly need those medications. I hope their voice is considered in all of this. Thank you.

Dr. Laura Lizakowski

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NORTH DAKOTA
PSYCHIATRIC
SOCIETY

A District Branch of the
American Psychiatric Association

October 9, 2017

Bonnie Storbakken
Executive Secretary
North Dakota Board of Medicine
418 E Broadway Ave, Suite 12
Bismarck, ND 58501

Dear Ms. Storbakken:

On behalf of the North Dakota Psychiatric Society, I would like to offer our support of the Board of Medicine's proposed telemedicine administrative rules, with one suggested change.

The rule as currently written would require an in-person visit for every prescription of medication used for Medication Assisted Treatment (MAT). Medication such as Buprenorphine is technically an opioid, and therefore, under the current draft of the rules, would require an in-person visit every time it is prescribed. This may act as a disincentive for follow up visits if every visit to obtain medication must be in person.

Telemedicine, a key innovation in support of health care delivery reform, is being used in initiatives to improve access to care, care coordination and quality, as well as reduce the rate of growth in health care spending. Patients in rural areas of North Dakota have to drive long distances to get to a treatment center or to see an addiction specialist for medication-assisted treatment. Telemedicine could reduce the burden of this barrier.

The North Dakota Psychiatric Society supports policies that carefully regulate the adoption of telemedicine, while still allowing physicians to more easily and readily connect to their patients and facilitate consultations through these technologies. The proposed rules, with the amendment with regard to MAT, would accomplish this.

Thank you for your leadership on this issue.

Sincerely,

Emmet Kenney, MD
President, ND Psychiatric Society

1622 East Interstate Avenue • Bismarck ND 58503-0512 • 701-223-9475 • Fax: 701-223-9476

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OCT 0 9 2017

Allergy & Asthma NETWORK

8229 Boone Boulevard, Suite 260, Vienna VA 22182 · 800.878.4403 · *AllergyAsthmaNetwork.org*

October 9, 2017

North Dakota Board of Medicine
418 E. Broadway Avenue, Suite 12
Bismarck, North Dakota 58501

Re: Proposed rules pertaining to telemedicine

Dear Members of the North Dakota Board of Medicine:

Allergy & Asthma Network supports telemedicine legislation and regulations that maximize allowable technologies and enable patients to have greater access to high-quality care. As the leading national nonprofit dedicated to protecting and improving the health of people with asthma, allergies and related conditions, we believe progressive policies regarding telemedicine are essential to fulfilling that goal.

In its current form, proposed regulation 50-02-15 inhibits North Dakotans ability to utilize telemedicine services for affordable, convenient care by including a medically-unnecessary provision requiring the use of audio-visual technology to establish a patient-license relationship. A high-speed Internet connection is needed to support streaming video, and many North Dakotans lack access to such broadband Internet service.

Physicians who deliver care through telemedicine should be held to the same standards as they would be if they were treating a patient in an office. Many patients who suffer from allergies, especially those with allergy-related skin conditions, would benefit from greater and more convenient access to a physician. For patients with chronic respiratory conditions like asthma and COPD, telemedicine would be an effective way to provide disease education and improved disease management. This is particularly true in North Dakota's many rural areas, where visiting a physician's office could require traveling lengthy distances through adverse weather conditions.

We believe telemedicine functions as a complement to existing healthcare resources by increasing access to affordable medical treatment. Allergic reactions and related conditions can occur at any time, and patients should have the option to pursue treatment through telemedicine rather than traveling to a hospital's emergency room in the middle of the night.

We respectfully request that the Board remove the audio-visual mandate from the proposed regulation. Thank you for your attention to this matter.

Sincerely,

Tonya A. Winders

Tonya Winders
President and CEO

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3-25-19

new benefits
creating advantage.

October 6, 2017

VIA EMAIL

North Dakota Board of Medicine
418 E Broadway Ave, Suite 12
Bismarck, ND 58501

Dear Members of the Committee:

I am writing on behalf of New Benefits to request that the proposed telemedicine regulations (Rule 50-02-05-03) before you be amended to allow the patient-license relationship to be established via interactive audio as well as through video. We believe the state should create telemedicine policies that preserve consistent standards and allow physicians to use their knowledge and experience in deciding whether to use modern technology to provide care, without narrowly defining allowable technologies.

For more than a decade, we have offered telemedicine services through Teladoc to our members. Although New Benefits is headquartered in Texas, our presence in North Dakota is substantial. We work with clients such as MBI Energy Services, Cracker Barrel, and Red Lobster, as well as a number of small businesses and school systems. We connect North Dakota residents with North-Dakota licensed physicians, who provide affordable, high-quality treatment of common, non-emergency ailments, and we have received virtually no complaints. Our experience is telemedicine provides patients with high-quality care that is safe, secure, timely and cost-effective.

My hope is that the Board will incorporate technology neutral language into rule 50-02-05-03 which does not require audio-visual technology to establish the physician-patient relationship via telemedicine.

This one change will position North Dakota to take advantage of telemedicine to address the significant areas of the state currently medically underserved and provide employers with a much-needed tool to manage health care costs.

I would be pleased to answer any questions you may have about our experience with telemedicine and can be reached at 1-800-800-8304 x1615.

Sincerely,

Joel Ray

Joel Ray, CEO

14240 Proton Road, Dallas, Texas 75244 + 800.800.8304 + 972.404.8192 + 972.991.5218 fax + www.NewBenefits.com

#1
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3-25-19

United Spinal Association

www.unitedspinal.org

October 13, 2017

North Dakota Board of Medicine
418 E Broadway Ave, Suite 12
Bismarck, ND 58501

Re: Chapter 50-02-15 and the use of telemedicine

Dear Members of the Board:

United Spinal Association writes to submit public comments requesting that that the language in draft regulation Chapter 50-02-15 be amended. We understand the formal comment period has just passed, but we hope that our organization's views will be considered at the board meeting next week as you take up the issue of telemedicine. Specifically, amending the restrictive language carving out allowable technology in telemedicine will allow the state of North Dakota to maximize expanded access to healthcare for people with disabilities through telemedicine. United Spinal Association supports public policies to promote and improve the quality of life for individuals with spinal cord injuries and diseases.

United Spinal Association is the largest disability-led national non-profit organization founded by paralyzed veterans in 1946 and has since provided service programs and advocacy to improve the quality of life of those across the life span living with spinal cord injuries and disorders (SCI/D) such as multiple sclerosis, amyotrophic lateral sclerosis (ALS), post-polio syndrome and spina bifida. United Spinal represents over one million individuals with spinal cord injuries and disorders, over 50 chapters, over 100 rehabilitation hospital members and close to 200 support groups nationwide. Throughout its history, United Spinal Association has devoted its energies, talents and programs to improving the quality of life for these Americans and for advancing their independence. United Spinal Association is also a VA-recognized veterans service organization (VSO) serving veterans with disabilities of all kinds.

United Spinal Association respectfully requests the Committee amend draft Chapter 50-02-15 to insert language in Section 3. Subsection (c) to explicitly allow the use of video in establishing the physician-patient relationship. The current requirement for audio-visual connections in establishing this relationship creates a barrier to access and removes another avenue for individuals with disabilities to obtain quality intervention via telemedicine.

Telemedicine is a valuable tool for meeting the needs of North Dakotans, particularly those with disabilities, and United Spinal Association strongly supports technology-neutral telemedicine regulations for the purpose of improving public access to high-quality health care. For people in rural areas and those living with spinal cord injuries or other physical disabilities, obtaining in-person care can be a difficult process.

While it is important that telemedicine providers be regulated to protect the public, it is equally important that policies not be designed to impede access. With the requested amendments, the state's telemedicine regulations would ensure that North Dakotans have greater access to medical care from providers that comply with federal and state requirements. If you have any questions, please do not hesitate to contact Jasey Cárdenas, Senior Policy Associate, at jcardenas@unitedspinal.org or (202) 556-2076, x7104.

Sincerely,

Alexandra Bennewith

Alexandra Bennewith, MPA
Vice President, Government Relations

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Lynette McDonald

From: Bonnie Storbakken
Sent: Friday, October 13, 2017 4:10 PM
To: Lynette McDonald
Subject: Fwd: United Spinal Association Comments on Chapter draft regulation 50-02-15
Attachments: image001.png; ATT00001.htm; United Spinal Association - ND Reg Chapter 50-02-15.pdf; ATT00002.htm

We may want to note that receipt of these was past our deadline but include anyway.

Sent from my iPhone

Begin forwarded message:

From: Jasey Cardenas <jcardenas@unitedspinal.org>
Date: October 13, 2017 at 3:17:36 PM CDT
To: "bstorbakken@ndbom.org" <bstorbakken@ndbom.org>
Cc: Alexandra Bennewith <ABennewith@unitedspinal.org>
Subject: United Spinal Association Comments on Chapter draft regulation 50-02-15

Hello,

United Spinal Association would like to submit our comments on draft regulation Chapter 50-02-15. We understand the formal comment period has just passed, but we hope that our organization's views will be considered at the board meeting next week as you take up the issue of telemedicine.

We are requesting that that the language in draft regulation Chapter 50-02-15 be amended. Specifically, amending the restrictive language carving out allowable technology in telemedicine will allow the state of North Dakota to maximize expanded access to healthcare for people with disabilities through telemedicine.

Please let me know if you have any questions. Have a great weekend!

About United Spinal Association:
United Spinal Association is the largest disability-led national non-profit organization founded by paralyzed veterans in 1946 and has since provided service programs and advocacy to improve the quality of life of those across the life span living with spinal cord injuries and disorders (SCI/D) such as multiple sclerosis, amyotrophic lateral sclerosis (ALS), post-polio syndrome and spina bifida. United Spinal has over 49,000 members and represents over one million individuals with spinal cord injuries and disorders, over 50 chapters, over 100 rehabilitation hospital members and close to 200 support groups nationwide. Throughout its history, United Spinal Association has devoted its energies, talents and programs to improving the quality of life for these Americans and for advancing their independence. United Spinal Association is also a VA-recognized veterans service organization (VSO) serving veterans with disabilities of all kinds.

Thank you,

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Jasey Cárdenas, Senior Policy Associate
United Spinal Association

1660 L Street NW, Suite 504
Washington, DC 20036
Office: 202-556-2076 ext. 7104 Fax: 202-223-2380
E-mail: jcardenas@unitedspinal.org Web: www.unitedspinal.org

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3-25-19

Lynette McDonald

From: Bonnie Storbakken
Sent: Monday, September 25, 2017 10:48 AM
To: Lynette McDonald
Subject: Fwd: Follow up from our discussion yesterday.

Not sure I sent this to you. This is the official comment of the Attorney General.

Sent from my iPhone

Begin forwarded message:

From: "Seibel, Troy T." <tseibel@nd.gov>
Date: September 22, 2017 at 10:33:53 AM CDT
To: Bonnie Storbakken <BStorbakken@ndbom.org>
Subject: RE: Follow up from our discussion yesterday.

Bonnie,

Yes, I think that accurately reflects what we discussed. Thanks.

Troy T. Seibel
Chief Deputy Attorney General
Office of Attorney General
600 E. Boulevard Ave., Dept. 125
Bismarck, ND 58505
701-328-2210
tseibel@nd.gov

From: Bonnie Storbakken [mailto:BStorbakken@ndbom.org]
Sent: Wednesday, September 20, 2017 2:34 PM
To: Seibel, Troy T. <tseibel@nd.gov>
Subject: Follow up from our discussion yesterday.

Hello Troy,
I wanted to clarify the official comments From the Attorney General regarding our PDMP rule before they are added to the comments for review by our board.

It is suggested that the Board consider adding the following language because they would be indicators that prescribers would notice and may be suggestive of an issue of one type or another regarding scheduled medications.

This language should be added to the list under section 3.

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1. Violating any prescribing agreement with the physician;
2. Frequently requests early refills of a reported drug for any reason;
3. Appears impaired or excessively sedated to the physician in any patient encounter;
4. Has a history of drug abuse or dependency.

Does this accurately reflect the comments that were intended to be considered?

Thank you,
Bonnie

Bonnie Storbakken
Executive Secretary
North Dakota Board of Medicine
418 East Broadway Ave.
Bismarck, ND 58501

(701)328-6500

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Bonnie Storbakken

From: info@ndbom.org
Sent: Tuesday, September 5, 2017 6:06 AM
To: Bonnie Storbakken
Subject: Contact Form Submission

Contact Form Submission: Please login to view at https://www.ndbom.org/admin/cgi-bin/contactadmin.pl.

www.ndbom.org/admin/cgi-bin/contactadmin.pl?action=display&contact_id=2798

Submitted values
Name = Paul Azure
Address = Wahpeton
City = Wahpeton
State = ND
Zip = 58075
Phone = 7014034898
Email = paulazure@hotmail.com
Comments = Trying to comment on the administration rules butt could not find the phone number that was supposed to be listed.Will make my comments here,if that is not acceptable call me.I question 50-05.02 reporting medication, and I ask that the full board review this rule and consider the effect this will have when the Congress eliminates federal health care.the cost of the uninsured to health care is going to have to come down or civil unrest and riots like you have never seen will start to happen.Perhaps this board should be eliminating rules and restrictions instead of making more.again I ask that the board consider the outcome of all of the proposed rules ,with the effect they will have on the uninsured population that will have to pay cash for their health care

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TELEMEDICINE RULE COMMENT

Attached are the rules comments we received following our public hearing on October 12th. The comment period ended October 23rd under law, but I've included all comments received, whether they arrived by that date or not.

Some, such as the ND Psychiatric Assn., ND Board of Pharmacy, Health Partners, Dr. Andy McLean, supported the rule as written.

There was a consistent theme for those suggesting changes and it dealt with follow-up care and on-call physicians within a group. Sometimes we get very close to an issue and, perhaps, what seemed pretty clear to me when drafting this rule may not have been clear to others. At any rate, I've drafted an additional paragraph to the rule that makes it clear that 1) follow up care, after a physician-patient relationship is established by the first examination or evaluation (in person or telemedicine), may be done in any way deemed appropriate by the physician or physician assistant. This would allow follow-up phone calls, emails, etc., which I know the board does not intend to prohibit; and 2) on call providers designated by a licensee would be covered by this, as well as the treating provider. I think this covers the objections listed by most of the commenters.

A suggestion by Teladoc, that we change the language and allow a phone call with asynchronous store and forward technology, is not clear to me, as I don't understand what that asynchronous store and forward material would be. Usually, that term is used to describe items such as radiology images, but I don't think that's what Teladoc means. They will be at the hearing, so perhaps we can get clarification on the point. Their language would greatly expand the use of just audio calls, as opposed to our standard language requiring a video component.

ATTORNEY GENERAL

Chairman Devlin called on Mr. Randy Miller, Executive Director, North Dakota Lottery, for testimony (Appendix C) regarding rules adopted by the Attorney General. Mr. Miller said rules are necessitated by the termination of the game, Hot Lotto, and its replacement, Lotto America.

STATE ELECTRICAL BOARD

Chairman Devlin called on Mr. Scott Porsborg, Special Assistant Attorney General, State Electrical Board, for testimony (Appendix D) regarding rules adopted by the State Electrical Board.

In response to a question from Representative Koppelman, Mr. Porsborg said it takes about 2 years to complete the required 576 hours of apprenticeship training classes.

GAME AND FISH DEPARTMENT

Chairman Devlin called on Mr. Scott Peterson, Deputy Director, Game and Fish Department, for testimony (Appendix E) regarding rules adopted by the Game and Fish Department. Mr. Peterson said the rules redefine legal live bait. He said this change eliminates the need for bait vendors who handle only terrestrial live bait to be licensed.

DEPARTMENT OF HUMAN SERVICES

Chairman Devlin called on Mr. Jonathan Alm, Legal Counsel, Department of Human Services, for testimony (Appendix F) regarding rules adopted by the Department of Human Services.

In response to a question from Representative Koppelman, Mr. Jim Fleming, Director, Child Support Division, Department of Human Services, said the guidelines are based on income. He said one of the deductions allowed in calculating net income is the cost of health insurance premiums. He said increasing health insurance premiums will have a corresponding effect on the amount of child support paid to an obligee.

Mr. Fleming said the change to the child support guidelines for those obligors with less than $700 per month in net income was done with the child support obligations of inmates in mind. He said eliminating or reducing the child support obligations of inmates allows an inmate to be released with a clean slate.

In response to a question from Senator Kilzer, Mr. Alm said the Department of Human Services is working with the Attorney General's office to develop a bill draft regarding a Medicaid fraud unit.

NORTH DAKOTA BOARD OF MEDICINE

Chairman Devlin called on Ms. Bonnie Storbakken, Executive Secretary, North Dakota Board of Medicine, for testimony (Appendix G) regarding rules adopted by the North Dakota Board of Medicine.

In response to a question from Senator Heckaman, Ms. Storbakken said 2015 legislation required licensing boards to adopt rules regarding participation in the prescription drug monitoring program. She said the Board of Medicine was awaiting the adoption of federal regulations before the board could finalize its rules.

In response to a question from Representative Koppelman, Ms. Storbakken said during the rules process, the Board of Medicine consulted with the Board of Nursing and the Board of Pharmacy. She said those boards have completed their rules on the prescription drug monitoring program.

In response to a question from Senator Anderson, Ms. Pam Sagness, Director, Behavioral Health Division, Department of Human Services, said Dr. Andrew McLean provided comments at the hearing regarding narcotic prescribing via telemedicine. She said the state did not have any opioid treatment providers in 2015. She said it is important to have further discussion and find solutions. She said access to the drugs used to treat opioid disorder should not be limited.

In response to a question from Representative Koppelman, Ms. Sagness said to prohibit the prescribing of drugs via telemedicine is too broad of a stroke since the treatment for opioid addiction includes drugs that are considered opioids.

Chairman Devlin called on Mr. John Ward, Teladoc. Mr. Ward introduced Dr. Donna Campbell, who is a member of the Texas Senate. Dr. Campbell provided testimony (Appendix H) regarding the telemedicine rules adopted by the North Dakota Board of Medicine.

In response to a question from Senator Anderson, Dr. Campbell said under Teladoc protocol, the doctor has the patient's record in view during the consultation. The doctor also may use high-definition photographs, and, if needed, video. She said telemedicine is not for complicated medical problems; however, a broad range of conditions can be handled by telemedicine. She said the doctor has the option of referring the patient to urgent care, the patient's primary care physician, or to an emergency room.

In response to a question from Representative Koppelman, Dr. Campbell said the lack of broadband access in some areas would make a required video consultation difficult for some patients. She said many people may not be technology savvy enough to use the equipment necessary for a video consultation.

In response to a question from Senator Heckaman, Dr. Campbell said the rule requiring the initial consultation to be conducted via video is arbitrary and capricious. She said a medical condition that creates the need for a second consultation may be unrelated and have no connection to the first visit with video.

In response to a question from Senator Anderson, Dr. Campbell said once the patient relationship is established, it is forever.

Chairman Devlin called on Dr. Jason Tibbels, Teladoc, for testimony regarding the telemedicine rules. Dr. Tibbels said physicians use professional judgment to make an informed decision regarding the care of the patient. He said that duty to make an informed decision is the same regardless of whether the consultation is done in person or via telemedicine. He said telemedicine is not a cure-all for all cases. He said the standard of care is the same whether it is the patient's 1st consultation or the 20th.

In response to a question from Senator Anderson, Dr. Tibbels said for telemedicine to be effective, the rules must use technology-neutral language. He also said the sharing of information is critical.

In response to a question from Senator Heckaman, Dr. Tibbels said Teladoc does not prescribe any controlled substances. However, he said, the treatment of opioids requires some prescribing of controlled substances. He said in his personal opinion, the opioid epidemic is huge and telemedicine should be permitted to be used to treat an epidemic.

Chairman Devlin called on Ms. Claudia Tucker, Vice President Government Affairs, Teladoc, for testimony (Appendix I) regarding the telemedicine rules. She said Teladoc is a very collaborative company. She said the company would be willing to participate in a database for the sharing of information.

In response to a question from Representative Koppelman, Ms. Tucker said Teladoc's issue with the Board of Medicine's telemedicine rule is the rule is not technology neutral.

Chairman Devlin said the committee was emailed letters regarding the rules from the Allergy & Asthma Network (Appendix J), The ERISA Industry Committee (Appendix K), AARP North Dakota (Appendix L), and the United Spinal Association (Appendix M).

It was moved by Senator Poolman, seconded by Representative Koppelman, and carried on a roll call vote to hold over to the next meeting the North Dakota Board of Medicine's rules on telemedicine on pages 90-91 of Supplement 367. Representatives Devlin, Boehning, Boschee, Koppelman, Louser, Pyle, Seibel, Toman, and Weisz and Senators Anderson, Armstrong, Heckaman, Kilzer, Klein, Poolman, and Rust voted "aye." No negative votes were cast.

STATE BOARD OF INDIAN SCHOLARSHIPS

Chairman Devlin called on Ms. Brenda Zastoupil, Director, Financial Aid, North Dakota University System, for testimony (Appendix N) regarding rules adopted by the State Board of Indian Scholarships.

In response to a question from Representative Boehning, Ms. Zastoupil said recipients of the scholarship must be North Dakota residents. She said the ability to provide documentation to prove eligibility has not been a problem.

STATE DEPARTMENT OF HEALTH

Chairman Devlin called on Mr. Dale Patrick, Radiation and Asbestos Control Program, State Department of Health, for testimony (Appendix O) regarding rules adopted by the State Department of Health.

In response to a question from Representative Boehning, Mr. Patrick said the department is notified of any repeals or changes to federal rules which may affect the department's rules.

Attachment 2a
of #1 Testimony

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Testimony of Bonnie Storbakken, Executive Secretary of the North Dakota Board of Medicine

Hello Chairman Devlin and members of the Administrative Rules Committee. My name is Bonnie Storbakken. I am the Executive Secretary for the North Dakota Board of Medicine. I am here today to discuss with you our telemedicine rule that was held over at your last meeting.

If you recall there was discussion at your meeting in December that there were a number of comments that were received regarding the request to allow the prescription of opioids through telemedicine for medication assisted treatment (MAT) purposes. It was the bulk of comments received pertaining to this issue that motivated us to hold the rule over to give our board an opportunity to review and fully consider these comments.

The second issue that was discussed at your meeting was the video requirement in establishing the Patient-Licensee Relationship. Additional comments regarding this issue were also received by the Administrative Rules Committee as well as by the Board. The Board reviewed the comments that were provided on this issue as well.

It is my intention to provide you with an overview of the action that was taken by our board after the December 5th Administrative Rules Committee meeting and help walk you through the changes that have been made to the rule. Once I finish with this I will introduce Dr. Brenda Miller to you who will provide a little more background of the discussions that have been had by our board regarding the requirements within the rule to establish a Patient-Licensee Relationship.

The actions taken by the NDBOM after the December Administrative Rules Committee Meeting:

1. The Board had a telephone conference meeting at which they appointed a telemedicine committee with decision making authority to assist with the review and possible amendment of the telemedicine rule.
2. The telemedicine committee met on January 4th and addressed the two main issues that were discussed at the Administrative Rules Committee Meeting:
    a. The Patient-Licensee Relationship: the committee felt this issue had been discussed by the full board and the decision of the board was to continue to require the three options under the rule to establish the patient-licensee relationship. They did not agree with the comments seeking to eliminate the language regarding the interactive video examination.
    b. The Prescribing of opioids for MAT purposes: the committee discussed this issue and thought that the rule should be amended to allow for this exception. The committee felt it was necessary to have clear language to allow for this exception to treat those with opioid addictions while still maintaining their commitment to assisting with the opioid issues currently facing our state.

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c. The committee directed Bonnie to work with the parties present to develop language for the opioid exception. The committee also directed Bonnie to work with legal counsel to ensure the current language regarding the Patient-Licensee Relationship was as clear as possible.
d. Additional comments were received and reviewed at this meeting including those comments received by your committee at the December meeting.

3. The telemedicine committee met again on February 9 to go over the language changes to the rule made by myself in consultation with our legal counsel and in consideration of the suggested changes by the Department of Health as well as the Association.
   a. The committee approved the bulk of amendments made to the rule and directed Bonnie to submit the final draft to the Administrative Rules Committee.
   b. Additional comments were received and reviewed by the committee at this meeting
4. The telemedicine committee met again on March 2 to discuss additional comments that Bonnie had received regarding language in the rule.
   a. The committee made two changes to the language at this final meeting. One change to its definition of telemedicine and one change to the numbering and formatting of the Patient-Licensee Relationship within the definitions section based on comments received.

Summary of Changes made to the Telemedicine Rule:

1. 50-02-15 The first change you see adds a statement to the definition of telemedicine to ensure that everyone understands that asynchronous store-and-forward technology does not mean patient supplied information only. This change was made after reviewing a comment received from CTel (Center for Telehealth and e-Health Law) which stated that some states were dealing with companies who were using only patient supplied information such as a questionnaire and defining it as asynchronous store-and-forward technology. The telemedicine committee felt this interpretation did not fit within their intended definition of asynchronous store-and-forward technology so this sentence was added,
2. 50-02-15 The second significant change made was to provide a definition of the Patient-Licensee Relationship in a clear bulleted fashion within the definitions section of the rule.
   a. This was done to try to be as clear as possible what it takes to establish the patient licensee relationship. There seemed to be an impression from many of the comments heard that video was the only way to establish a patient-licensee relationship.
   b. There was also a change in the language that defined what would not qualify as establishing a patient licensee relationship. The committee removed the word

static in front of the online questionnaire as it appeared through some verbal comments and questions received that there would be use of a drop down or branching questionnaire to establish the patient licensee relationship.

3. 50-02-15-03 (b) was changed to avoid confusion with the definition of patient licensee relationship. This section really went to describing the ability of the patient and provider to be able to verify the identity of each other.
4. 50-02-15-03 (c) this was changed to make clear how examinations must be conducted to establish a patient licensee relationship by referring to the definition.
    a. The subparagraph which allowed for follow up care to be done by examination at the discretion of the provider was changed to ensure that all would understand this was intended to allow for follow up care. Some of the comments seemed demonstrate a belief that the requirement to use video was only for the first visit and therefore arbitrary. The telemedicine committee wanted to ensure that follow up care would be permitted the same as it would be in most facilities. The committee wanted licensees to use their discretion on future visits once the patient-licensee relationship was established to the same degree utilized by licensees in a traditional medicine setting.
    b. The language regarding the exception to an independent examination was amended to make it clear which types of situations would not require an independent examination of the patient.
5. 50-02-15-03 (d) Medical records. We thought this change was needed to make clear what the expectation of records is to all licensees.
6. 50-02-15-04 Prescribing. There was a change in the language that prohibited the prescription of opioids. This language was proposed by the Department of Health and approved by the committee. The language you see today allows for prescription of opioids only within Medication Assisted Treatment (MAT) situation. This allows for the intent to limit the prescription of opioids as well as provide treatment to those with opioid addictions.

Attachments

1. Amended Telemedicine Rule
2. Additional comments that have been considered including those comments submitted to the Administrative Rules Committee in December
3. Additional References
    a. North Dakota Department of Human Services Medical policy regarding Telemedicine which requires face to face visual contact between the practitioner and patient in order to be reimbursed.
    b. CTel article entitled, "Telemedicine: Prescribing and the Internet". This article states that at the time of the article publication that 41 states and one territory required a physician to conduct an in-person or face-to-face exam of the patient before prescribing medication using telemedicine.

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c. Public Health Law article entitled "Prescription Drug Physical Examination Requirements".
d. Joint Statement on Antibiotic Resistance from 25 National Health Organizations and the Centers for Disease Control and Prevention
e. CDC Encourages Safe Antibiotic Prescribing and Use

4. Testimony of Dr. Brenda Miller

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ATTACHMENT 1

#2
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3-25-19

CHAPTER 50-02-15
TELEMEDICINE

50-02-15. Definitions. As used in this chapter,
"Telemedicine" means the practice of medicine using electronic communication, information technologies or other means between a licensee in one location and a patient in another location, with or without an intervening healthcare provide. It includes direct interactive patient encounters as well as asynchronous store-and-forward technologies and remote monitoring. Asynchronous store-and-forward technology is not patient only provided information.

"Licensee" means a physician or physician assistant licensed to practice in North Dakota. A physician assistant practicing telemedicine from another state is subject to the rules regarding physician supervision, except that supervision may be by a North Dakota licensed physician who is practicing telemedicine in North Dakota and need not be by a North Dakota licensed physician who is physically located in North Dakota.

"Patient-Licensee Relationship" means a relationship between a licensee and a patient established by any of the following means:

1. A face to face examination/evaluation of the patient by the licensee, or
2. An interactive video examination that utilizes appropriate peripheral and diagnostic testing, or
3. An examination conducted with an appropriate licensed intervening healthcare provider practicing within the scope of their profession and providing necessary physical findings to the licensee, and
4. All examinations or evaluations should be the equivalent to an in -person examination, and
5. The following will not be defined as establishing a patient-licensee relationship:
    i. An examination or evaluation that consists only of online questionnaire, audio only conversation, email only and or electronic communication only, or facsimile communication only.

General Authority: 28-32-02, NDCC
Statute Implemented: 43-17, NDCC

50-02-15-02. Licensure. The practice of medicine is deemed to occur in the state the patient is located. Practitioners providing medical care to patients located in North Dakota are subject to the licensing and disciplinary laws of North Dakota and must possess an active North Dakota license for their profession.

General Authority: 28-32-02, NDCC
Statute Implemented: 43-51-02 NDCC; 43-17, NDCC

50-02-15-03. Standard of care and professional ethics. Licensees are held to the same standard of care and same ethical standards whether practicing traditional, in-person, medicine or telemedicine. Therefore, the following apply in the context of telemedicine:

a) Scope of practice. Professional ethical standards require all practitioners to practice only in areas in which they have demonstrated competence, based on their training, ability and

experience. In assessing a licensee's compliance with this ethical requirement, consideration will be given to board certifications and specialty groups' telemedicine standards.

b) ~~Patient-Licensee relationship~~Verification requirements. A licensee practicing telemedicine must establish a valid ~~relationship with the patient~~patient-licensee relationship prior to the diagnosis and/or treatment of a patient. A licensee practicing telemedicine shall verify the identity of the patient seeking care; and disclose, ~~and ensure the patient has the ability to verify~~, the identity and licensure status of any licensee providing medical services to the patient. The patient must have the ability to verify the identity and licensure status of any licensee providing telemedicine services to the patient.

c) ~~Evaluations and examinations required to establish a p~~Patient-~~l~~Licensee ~~r~~Relationship. Evaluations and examinations. Prior to initially diagnosing or treating a patient for a specific illness or condition, an examination or evaluation must be performed. An examination or evaluation may be performed entirely through telemedicine, if the examination or evaluation is equivalent to an in-person examination as defined under the "Patient-Licensee relationship". ~~A video examination that utilizes appropriate diagnostic testing and use of peripherals that would be deemed necessary in a like in-person examination or evaluation would meet this standard, as would an examination conducted with an appropriately licensed intervening health care provider, practicing within the scope of their profession, providing necessary physical findings to the licensee. An examination or evaluation that consists only of a static online questionnaire or an audio conversation will not be considered to meet the standard of care.~~

Once a licensee conducts an acceptable examination or evaluation, whether in-person or by telemedicine, and establishes a patient-licensee relationship, subsequent follow-up care may be provided as deemed appropriate by the licensee, or by a provider designated by the licensee to act temporarily in the licensee's absence. If three or more years passes between the initial evaluation or examination and consistent care has not been provided by the licensee, another examination evaluation under this rule must be conducted prior to additional diagnosis and or treatment.

It is ~~recognized that in certain types of telemedicine utilizing asynchronous store-and-forward technology or electronic monitoring, such as tele-radiology or ICU monitoring, it is~~ not medically necessary for an independent examination of the patient to be performed in certain types of telemedicine that utilize asynchronous store-and-forward technology or electronis monitoring such as teleradiology or electronic ICU monitoring.~~.~~

d) Medical records. Licensees practicing telemedicine are subject to all North Dakota laws governing the adequacy of medical records and the provision of medical records to the patient and other medical providers treating the patient. Thus, any provider treating a patient via telemedicine must maintain adequate medical records for each encounter that are available to the patient and other providers.

e) Licensees must have the ability to make appropriate referrals of patients not amenable to diagnosis or complete treatment through a telemedicine encounter, including those patients in need of emergent care, or complementary in-person care.

General Authority: 28-32-02, NDCC

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Statute Implemented: 43-17-31, NDCC

50-02-15-04. Prescribing. A licensee who has performed a telemedicine examination or evaluation meeting the requirements of this chapter may prescribe medications according to the licensee's professional discretion and judgment, with one exception: ~~Licensees may not prescribe opioids through a telemedicine encounter.~~ Opioids may only be prescribed through telemedicine if done so as a FDA approved medication assisted treatment (MAT) for opioid use disorder. Opioids may not be prescribed through a telemedicine encounter for any other purpose.

Licensees who prescribe controlled substances, as defined by North Dakota law, in circumstances allowed under this rule, must comply with all state and federal laws regarding the prescribing of controlled substances, and must participate in the North Dakota Prescription Drug Monitoring Program.

General Authority: 28-32-02, NDCC
Statute Implemented: 19-02.1-15.1, NDCC; 19-03.1-22.4, NDCC; 19-03.5-09(2), NDCC; 43-17 , NDCC

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ATTACHMENT 2

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APPENDIX I

TELADOC.

December 4, 2017

The Honorable Bill Devlin
Chairman, Administrative Rules Committee
North Dakota Legislative Assembly
P.O. Box 505
Finley, North Dakota 58230-0505

Dear Chairman Devlin and members of the North Dakota Administrative Rules Committee:

Teladoc appreciates this opportunity to provide its comments to the North Dakota Administrative Rules Committee on the proposed rules submitted by the North Dakota Board of Medicine ("Board") relating to Telemedicine Services. Teladoc respects the role of the Board in considering the appropriate rules and clinical practice guidelines that are designed to be protective of public health and maintain high-quality care for patients.

Teladoc has vast experience in telemedicine as it is the nation's first and largest telehealth platform, delivering on-demand healthcare anytime, anywhere, via mobile devices, a web-based portal, video and interactive audio. Teladoc provides services in all fifty states and has over 20.1 million enrollees, who benefit from access to Teladoc 24 hours a day, seven days a week, 365 days a year. After more than a decade of service and over 2.5 million telehealth visits, Teladoc has yet to be subject to a single malpractice claim.

Teladoc has expressed its concerns with the North Dakota Board of Medicine's proposed rules under NDAC 50-02-15 and specifically with NDAC 50-02-05-03(c) entitled Evaluations and examinations required to establish a patient-licensee relationship, as follows:

> "Prior to initially diagnosing or treating a patient for a specific illness or condition, an examination or evaluation must be performed. An examination or evaluation may be performed entirely through telemedicine, if the examination is equivalent to an in-person examination. A video examination that utilizes appropriate diagnostic testing and use of peripherals that would be deemed necessary in a like in-person examination or evaluation would meet this standard, as would an examination conducted with an appropriately licensed intervening health care provider, practicing within the scope of their profession, providing necessary physical findings to the licensee. An examination or evaluation that consists only of a static online questionnaire or an audio conversation will not be considered to meet the standard of care."

Teladoc's primary concern with the above excerpted passage is that limiting the establishment of the patient licensee relationship to a video examination it is too restrictive and lacks evidentiary support. The language is too restrictive in the respect that it fails to include the use of interactive audio as a means of initially establishing the patient-licensee relationship. The efficacy of Telehealth utilizing interactive audio has been shown through peer-reviewed literature and also

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seems to be conceived of by the North Dakota State Legislature in its recent passage of NDCC § 26.1-36-09.15(g), which defines telehealth as follows:

> g. "Telehealth":
>
> (1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.
>
> (2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.
>
> (3) Does not include the use of audio-only telephone, electronic mail, or facsimile transmissions.

NDCC § 26.1-36-09.15 includes within its definition "interactive audio" as a method of delivery of Telehealth services that all health insurance plans must cover in the State of North Dakota. The North Dakota Board of Medicine's decision to exclude interactive audio as a means of establishing a patient-licensee relationship has not been supported by any evidentiary finding, identified health care concern or any peer-reviewed literature that supports the necessity for video as a component in establishing the patient-licensee relationship in every telemedicine visit. Rather than providing any evidentiary basis for the necessity of a video component at the initial stage, the Board seems to have arbitrarily excluded interactive audio in the proposed rule.
Teladoc submits the following amendment to 50-02-05-03 for the Administrative Rules Committee's consideration that tracks with best practices on telemedicine policy throughout the country:

> c) Evaluations and examinations required to establish a patient-license relationship. Prior to initially diagnosing or treating a patient for a specific illness or condition, an examination or evaluation must be performed. An examination or evaluation may be performed entirely through telemedicine, if the examination or evaluation is equivalent to an in-person examination. A video examination that utilizes appropriate diagnostic testing and use of peripherals that would be deemed necessary in a like in-person examination or evaluation would meet this standard, the use of interactive audio with asynchronous store and forward technology or audio-video, at the professional discretion of the physician, would meet this standard as would an examination conducted with an appropriately licensed intervening health care provider, practicing with the scope of their profession, providing necessary physical findings to the licensee. An examination or evaluation that consists only of a static online questionnaire or an audio conversation "in isolation" will not be considered to meet the standard of care.

It seems almost an absurdity to assume that a North Dakota licensed physician would perform a Telemedicine visit or provide an examination or evaluation by Telemedicine without having the appropriate information available to the licensee, as the circumstances dictate. In this way,

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Teladoc suggests that the restrictive language in the proposed rule usurps the licensee's discretion and replaces it with an arbitrary rule that excludes another method of delivery of telemedicine services.

It is also important to recognize that North Dakota is a largely rural state and individuals that reside in areas with limited access to broadband or high-speed telecommunications services may not be able to obtain telemedicine services due to their inability to utilize a video platform. Furthermore, certain individuals that are seeking care by telemedicine may also prefer a telehealth visit established by interactive audio, for example, over video. There has been significant use of telemedicine in the field of telemental health, telepsychiatry or telebehavioral health ("telemental health"). Telemental health services are utilized effectively in the treatment of various types of mental health disorders including anxiety, agoraphobia, substance abuse, and PTSD. Many patients may have issues with receiving treatment for such disorders due to perceived stigmas and may be more inclined to seek to treatment through telemedicine. Some telemental health patients may even prefer to initiate a telemedicine visit by interactive audio rather than through video. Consequently, the Board's restrictive rules for establishing the patient-licensee relationship, potentially excluding interactive audio, may leave many North Dakotans without access to care that is not available to them due to the unavailability of broadband internet services or care with which they are comfortable.

Telemedicine is a potential solution to issues related to healthcare access in communities that lack sufficient facilities and/or practitioners to address their needs locally. A small town in North Dakota may not have a hospital or physician available to address an identified health care need. Having widely accepted technologies, such as interactive audio, available to a licensee in providing telemedicine to North Dakota patients seems to be a reasonable goal for North Dakota and this Administrative Rules Committee. Utilizing technology specific language will almost certainly limit the availability and access to telemedicine of North Dakotans, which will disproportionately fall on those in rural communities where Telemedicine would have its most beneficial application.

Any alleged concerns that licensees would practice telemedicine in a substandard manner should be offset by the Board's authority to review a licensee practicing telemedicine in North Dakota and discipline such an individual for a violation of the appropriate standard of care. Just as the board disciplines licensees practicing traditional, in-person medicine. In fact, many states policy on telehealth is nothing more than a statement that Licensees are held to the same standard of care and [the] same ethical standards..." while practicing Telemedicine as those practicing "traditional, in-person medicine" and nothing more.

Teladoc encourages the use of technology neutral language that will allow for future development and innovation in the field of telemedicine. Teladoc also points to a potential conflict with the legislative intent of NDCC 26.1-36-09.15 in providing for telehealth services, including interactive audio, where the proposed administrative rule restricts the provision of telehealth services by interactive audio. Pursuant to NDCC 28-32-18, there has been no showing by the Board of Medicine that it has fully considered the multiple comments that it received

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requesting that the Board include interactive audio as a means of establishing the patient-licensee relationship. Finally, there does not appear in the record any substantive discussion as to the board's analysis in restricting the establishment of the patient-licensee relationship to a video examination. The Board's restricting the establishment of the patient-licensee relationship to a video examination is arbitrary and, accordingly, this Administrative Rules Committee should either amend NDAC 50-02-05-03(c), as suggested herein or strike the language in the first paragraph of NDAC 50-02-05-03(c) appearing after the sentence "An examination or evaluation may be performed entirely through telemedicine, if the examination or evaluation is equivalent to an in-person examination."

Teladoc appreciates the opportunity to comment on the proposed regulations. If you need more information or have any questions, please do not hesitate to contact me at (434) 841-3716.

Best Regards,

Claudia Tucker
Vice President Government Affairs
Teladoc

cc: Senator Nicole Poolman, Vice Chair
Representative Randy Boehning
Representative Joshua A. Boschee
Representative Kim Koppelman
Representative Scott Louser
Representative Brandy Pyle
Representative Mary Schneider
Representative Jay Seibel
Representative Nathan Toman
Representative Robin Weisz
Senator Howard Anderson, Jr.
Senator Kelly Armstrong
Senator Ralph Kilzer
Senator Jerry Klein
Senator Scott Meyer
Senator David Rust

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APPENDIX J

Allergy & Asthma NETWORK

8229 Boone Boulevard, Suite 260, Vienna VA 22182 · 800.878.4403 · *AllergyAsthmaNetwork.org*

November 29, 2017

Administrative Rules Committee
c/o Vonette Joy Richter, Code Reviser
Legislative Council
600 East Boulevard Avenue
Bismarck, North Dakota 58505-0360

Dear Chairman Devlin and members of the Administrative Rules Committee:

On behalf of Allergy & Asthma Network, I respectfully request draft regulation 50-02-15 be reconsidered due to concerns about the regulation's potential negative impact on patients and health care in North Dakota. We previously submitted comment to the Board of Medicine requesting an amendment of the draft regulation to eliminate restrictive language and expand care options while preserving patient safety.

High-quality telemedicine is an important part of a modern and efficient healthcare system, and Allergy & Asthma Network is committed to working with policymakers to develop legislation and regulations that appropriately balance patient safety and access to treatment.

If you have any questions or need more information, please contact me or our Director of Advocacy, Charmayne Anderson at 703-641-9595. We appreciate your service and consideration.

Sincerely,

Tonya A. Winders

Tonya A. Winders
President and CEO

Attachment: Letter to North Dakota Board of Medicine

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Allergy & Asthma NETWORK

8229 Boone Boulevard, Suite 260, Vienna VA 22182 · 800.878.4403 · *AllergyAsthmaNetwork.org*

October 9, 2017

North Dakota Board of Medicine
418 E. Broadway Avenue, Suite 12
Bismarck, North Dakota 58501

Re: Proposed rules pertaining to telemedicine

Dear Members of the North Dakota Board of Medicine:

Allergy & Asthma Network supports telemedicine legislation and regulations that maximize allowable technologies and enable patients to have greater access to high-quality care. As the leading national nonprofit dedicated to protecting and improving the health of people with asthma, allergies and related conditions, we believe progressive policies regarding telemedicine are essential to fulfilling that goal.

In its current form, proposed regulation 50-02-15 inhibits North Dakotans ability to utilize telemedicine services for affordable, convenient care by including a medically-unnecessary provision requiring the use of audio-visual technology to establish a patient-license relationship. A high-speed Internet connection is needed to support streaming video, and many North Dakotans lack access to such broadband Internet service.

Physicians who deliver care through telemedicine should be held to the same standards as they would be if they were treating a patient in an office. Many patients who suffer from allergies, especially those with allergy-related skin conditions, would benefit from greater and more convenient access to a physician. For patients with chronic respiratory conditions like asthma and COPD, telemedicine would be an effective way to provide disease education and improved disease management. This is particularly true in North Dakota's many rural areas, where visiting a physician's office could require traveling lengthy distances through adverse weather conditions.

We believe telemedicine functions as a complement to existing healthcare resources by increasing access to affordable medical treatment. Allergic reactions and related conditions can occur at any time, and patients should have the option to pursue treatment through telemedicine rather than traveling to a hospital's emergency room in the middle of the night.

We respectfully request that the Board remove the audio-visual mandate from the proposed regulation. Thank you for your attention to this matter.

Sincerely,

Tonya L. Winders

Tonya Winders
President and CEO

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The ERISA Industry Committee

Driven By and For Large Employers
1400 L Street, NW, Suite 350, Washington, DC 20005 • (202) 789-1400 • www.eric.org

Adam Greathouse, Health Policy Associate

December 4, 2017

Administrative Rules Committee
North Dakota Legislative Council
600 E. Boulevard Ave.
Bismarck, ND 58505-0360

RE: Comment on Proposed Telemedicine Rules for December 5, 2017 Administrative Rules Committee Meeting

Delivered via email to vrichter@nd.gov

Dear Chairman Devlin and Members of the Administrative Rules Committee:

On behalf of The ERISA Industry Committee (ERIC), thank you for accepting input from interested stakeholders as you consider the North Dakota Board of Medicine's proposed rules regarding telemedicine. ERIC is the only national association that advocates exclusively for large employers on health, retirement, and compensation public policies at the federal, state, and local levels. We speak in one voice for our members on their benefit and compensation interests, including many members with employees and retirees in North Dakota.

As plan sponsors, our members strive to provide the best health care possible to their employees, retirees, and families at an affordable cost. At ERIC, we seek to enhance our members' ability to provide high-quality, affordable health care, and we recognize the significant opportunity provided by telemedicine to modernize health care delivery and improve access to quality medical care for workers and their dependents. Telemedicine minimizes the time spent attending a health care provider visit, making telehealth a great value to working parents, caregivers, and others struggling to balance work and family demands. It also provides access to care for rural and urban underserved populations, retirees, the elderly, disabled employees, and those with language barriers, chronic conditions, or transportation barriers that may otherwise not have access to care.

We applaud the Board of Medicine's proposed rules providing for the same standard of care for telemedicine visits as for those conducted in-person and for permitting the patient-licensee relationship to be established via telemedicine. The benefits of telemedicine will be greatly diminished if it can only be used by those with preexisting patient-licensee relationships. For example, many people that have recently moved for work, college students, those in need of a specialist, or those that have never been to a health care provider would not be able to utilize telemedicine services if a preexisting relationship was required.

In Proposed Rule 50-02-05-03, however, to establish a patient-licensee relationship via telemedicine, the mode of delivery must be by video examination, even though the Board's proposed telemedicine definition includes "asynchronous store-and-forward technologies." We encourage you to send these rules back to the Board to reconsider the restrictive video requirement to establish the patient-licensee relationship. The State Legislature defined telehealth in 2015 as "the use of interactive audio, video, or other communications technology that is used

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by a health care provider or health care facility at a distant site to deliver health services at an originating site...." At ERIC, we support technology-neutral requirements in telemedicine regulations because restrictive requirements create a barrier to access—especially in rural areas where a significant proportion of the population lacks access to a fast, reliable internet connection capable of two-way audio-video communication.

We believe that it should be within the health care provider's professional judgment to determine if a telemedicine visit will meet the requisite standard of care and what type of technology is appropriate to establish a relationship with a certain patient. Additionally, restrictive technology requirements prevent new forms of telemedicine technology, which are ever-evolving, from being quickly implemented. Patients should not be prevented from using telemedicine solely because they lack the capability to communicate with a provider via video. We request that the Board of Medicine consider allowing interactive audio in conjunction with asynchronous store-and-forward technology to be used to establish the patient-licensee relationship.

Thank you for accepting our input on this rule. ERIC is pleased to represent large employers with the goal of ensuring telemedicine benefits are accessible for millions of workers, retirees, and their families. If you have any questions concerning our written testimony, or if we can be of further assistance, please contact Adam Greathouse at agreathouse@eric.org or 202-627-1914.

Sincerely,

Adam J. Greathouse
Health Policy Associate

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APPENDIX L

AARP Real Possibilities in North Dakota

107 W. Main Avenue, #125 ¦ Bismarck, ND 58501
1-866-554-5383 ¦ Fax: 701-255-2242 ¦ TTY: 1-877-434-7598
aarp.org/nd ¦ aarpnd@aarp.org ¦ twitter: @AARP_ND
facebook.com/AARPND

December 1, 2017

VIA EMAIL

North Dakota Administrative Rules Committee
600 East Boulevard Avenue
Bismarck, ND 58505-0360

Dear Chairman Devlin and Members of the Committee:

We appreciate the efforts of both the Committee and the North Dakota Board of Medicine to safely regulate telemedicine in the state. On behalf of AARP North Dakota and our approximately 86,000 members in the state, AARP respectfully requests the Committee reject the proposed telemedicine regulations before you in order that Chapter 50-02-15 may be amended to remove restrictive technology requirements in Rule 50-02-05-03.

The increased attention directed toward telemedicine is understandable. As a new, promising tool for delivering care, it holds tremendous potential to eliminate barriers that hinder efforts to provide treatment and care. This is true not only for residents in rural and medically underserved areas but for patients across the state who have issues with mobility and travel. AARP believes that telemedicine offers an option for coordinating and obtaining high-quality care that is practical, affordable and effective, as not every medical condition warrants an arduous trip to an office, urgent care clinic or hospital emergency room.

Expanding the use of telemedicine can help individuals and family caregivers access health care and long-term services and supports in new ways, allowing individuals to live independently in their homes and communities and making it easier for family caregivers, many of whom work full time, to care for their loved ones. When one takes into account that in North Dakota there are approximately 62,100 family caregivers providing $860 million in unpaid care for their loved ones, telemedicine can play a meaningful role in helping not only patients, but also family caregivers who oftentimes are providing the bulk of that patient's care.

This proposal, as currently drafted, has potential to impede access to healthcare via telemedicine for patients, as well as their family caregivers, across North Dakota due to the requirement that the patient-provider relationship be established via video examination. Such a move would inappropriately reduce patient access to care and would represent North Dakota swimming against the national current of states expanding, not restricting, access to telemedicine.

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Please let us know if you need us to submit additional correspondence or provide testimony on this matter, or other ways we can demonstrate our view on this important issue.

Kind regards,

Josh Askvig
State Director
AARP North Dakota

cc: Executive Secretary Bonnie Storbakken, North Dakota Board of Medicine

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APPENDIX M

United Spinal Association
www.unitedspinal.org

December 4, 2017

Administrative Rules Committee c/o
Vonette Joy Richter, Attorney at Law
Legislative Council
600 E. Boulevard Ave.
Bismarck, ND 58505-0360

Dear Chairman Devlin and members of the Administrative Rules Committee:

Please see the enclosed letter from the United Spinal Association to the Board of Medicine in which we requested an amendment to draft regulation 50-02-15 as it pertains to the use of telemedicine in North Dakota. This request was not considered favorably, and United Spinal Association remains concerned about the restrictive nature of these regulations and their impact on patients across North Dakota, in particular those with spinal cord injuries and disorders. North Dakota is a heavily rural state with many residents who lack access to broadband, and the practical effect of the Board's proposed regulations would be to eliminate the use of telemedicine for a vast majority of the state's residents.

We ask that you consider the importance of telemedicine and its ability to improve access to healthcare for individuals with spinal cord injuries and other types of physical disabilities, and all North Dakota patients, as you assess these proposed regulations.

While it is important that telemedicine providers be regulated to protect the public, it is equally important that policies not be designed to impede access. With the requested amendments, the state's telemedicine regulations would ensure that North Dakotans have greater access to medical care from providers who comply with federal and state requirements. If you have any questions, please do not hesitate to contact Jasey Cárdenas, Senior Policy Associate, at jcardenas@unitedspinal.org or (202) 556-2076, x7104.

Sincerely,

Alexandra Bennewith

Alexandra Bennewith, MPA
Vice President, Government Relations

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United Spinal Association
www.unitedspinal.org

October 13, 2017

North Dakota Board of Medicine
418 E Broadway Ave, Suite 12
Bismarck, ND 58501

Re: Chapter 50-02-15 and the use of telemedicine

Dear Members of the Board:

United Spinal Association writes to submit public comments requesting that that the language in draft regulation Chapter 50-02-15 be amended. We understand the formal comment period has just passed, but we hope that our organization's views will be considered at the board meeting next week as you take up the issue of telemedicine. Specifically, amending the restrictive language carving out allowable technology in telemedicine will allow the state of North Dakota to maximize expanded access to healthcare for people with disabilities through telemedicine. United Spinal Association supports public policies to promote and improve the quality of life for individuals with spinal cord injuries and diseases.

United Spinal Association is the largest disability-led national non-profit organization founded by paralyzed veterans in 1946 and has since provided service programs and advocacy to improve the quality of life of those across the life span living with spinal cord injuries and disorders (SCI/D) such as multiple sclerosis, amyotrophic lateral sclerosis (ALS), post-polio syndrome and spina bifida. United Spinal represents over one million individuals with spinal cord injuries and disorders, over 50 chapters, over 100 rehabilitation hospital members and close to 200 support groups nationwide. Throughout its history, United Spinal Association has devoted its energies, talents and programs to improving the quality of life for these Americans and for advancing their independence. United Spinal Association is also a VA-recognized veterans service organization (VSO) serving veterans with disabilities of all kinds.

United Spinal Association respectfully requests the Committee amend draft Chapter 50-02-15 to insert language in Section 3. Subsection (c) to explicitly allow the use of video in establishing the physician-patient relationship. The current requirement for audio-visual connections in establishing this relationship creates a barrier to access and removes another avenue for individuals with disabilities to obtain quality intervention via telemedicine.

Telemedicine is a valuable tool for meeting the needs of North Dakotans, particularly those with disabilities, and United Spinal Association strongly supports technology-neutral telemedicine regulations for the purpose of improving public access to high-quality health care. For people in rural areas and those living with spinal cord injuries or other physical disabilities, obtaining in-person care can be a difficult process.

While it is important that telemedicine providers be regulated to protect the public, it is equally important that policies not be designed to impede access. With the requested amendments, the state's telemedicine regulations would ensure that North Dakotans have greater access to medical care from providers that comply with federal and state requirements. If you have any questions, please do not hesitate to contact Jasey Cárdenas, Senior Policy Associate, at jcardenas@unitedspinal.org or (202) 556-2076, x7104.

Sincerely,
Alexandra Bennewith
Alexandra Bennewith, MPA
Vice President, Government Relations

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Bonnie Storbakken

From: Etherington, Rosalie R. <retherington@nd.gov>
Sent: Monday, December 4, 2017 7:09 PM
To: Bonnie Storbakken
Subject: Regulatory Rules Committee NDBOM

Ms. Storbakken and members of the Regulatory Rules Committee

I write to you with concern regarding the decision to not allow telemedicine prescribing for suboxone or buprenorphine. These medications are effective in medication assisted treatment of opioid use disorders. The fact that the board has chosen to be even more restrictive than the current federal rules that allow telemedicine prescribing after an in-person examination is eliminating this choice of treatment for rural North Dakotans.

There are only 65 practicing psychiatrists in North Dakota. This small number of physicians coupled with our frontier and rural counties, plus the distance necessary for patients to travel, eliminates the possibility for use of these effective medications. The public behavioral health system serves more than 10,000 North Dakotan's per year, many of whom suffer from severe substance use disorders. To maximize access to needed care we rely on telemedicine for prescribing and counseling. The limiting of these medications for use in telemedicine will adversely affect our clients, some of the poorest and most vulnerable citizens of our state.

Thank you for your attention to this matter and consideration of bringing this forward to the board.

Rosalie Etherington, PhD
Chief Clinics Officer, DHS Human Service Centers
Superintendent, North Dakota State Hospital
retherington@nd.gov
701-253-3964

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Bonnie Storbakken

From: -Info-Dept. of Health <health@nd.gov>
Sent: Thursday, December 14, 2017 1:53 PM
To: Bonnie Storbakken
Subject: FW: Incident# 1050239 - North Dakota State Portal Inquiry forwarded from the Service Desk

Follow Up Flag: Flag for follow up
Flag Status: Flagged

The ITD Service Desk forwarded this to the State Health Department.

Londa

From: ITD Service Desk
Sent: Thursday, December 14, 2017 12:48 PM
To: -Info-Dept. of Health <health@nd.gov>
Subject: Incident# 1050239 - North Dakota State Portal Inquiry forwarded from the Service Desk

Hello Health, Dept. of,

Please respond to the inquiry that was submitted from the 'Contact Us' form on the State Portal site. If your agency is unable to fulfill this inquiry please contact the Service Desk.

Name: Chase Larson
Email: clarson@evisit.com

Description:
Contact Us inquiry

To whom it may concern,

My name is Chase Larson and as Director of Marketing, I speak on behalf of the national telemedicine company eVisit.

We would like to formally stand with the North Dakota Board of Medicine and their proposed rule that would require an in-person visit for a patient's first telemedicine appointment.

As an entity offering telemedicine to hundreds of thousands of patients, we have seen great success when the initial doctor-patient relationship has had the adequate opportunity to foster trust, care and accuracy. Though this may require more time and effort upfront, we know this investment pays great dividends over the duration of the virtually administered healthcare. In the end, more adoption comes as a result and those in the more rural reaches of the state are afforded greater access.

The Board of Medicine has our full support in this endeavor. Please let eVisit know if we can offer anything additional in the effort to provide North Dakota residents the best healthcare experience possible.

Best regards,
Chase Larson
clarson@evisit.com

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Bonnie Storbakken

From: Hirsch, Robin A. <rhirsch@nd.gov>
Sent: Wednesday, November 15, 2017 10:18 AM
To: Bonnie Storbakken
Cc: Ideker, Maureen; Shropshire, Kimberly
Subject: Maureen's info

Maureen's information

She was asking about the "branching algorithm" questionnaire vs a "state" questionnaire

Maureen Ideker RN, BSN, MBA
System Director of Telehealth
Essentia Health
Holy Trinity Hospital
115 West Second Street, Graceville, MN 56240
C: 218-371-0596
maureen.ideker@essentiahealth.org

Thanks!

Robin Hirsch

Human Resource Officer
Information Technology Dept.
4201 Normandy Street
Bismarck, ND 58503-1324
701.328.3175
rhirsch@nd.gov

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3-25-19

Bonnie Storbakken

From: Tufte, Mylynn K. <mylynntufte@nd.gov>
Sent: Tuesday, December 19, 2017 11:17 AM
To: Tufte, Mylynn K.
Subject: HIPAA guidance related to opioid crisis - New Resource

Greetings,

This was recently shared from our Regional Federal partners. I believe this to be encouraging in light of our expansion of medication assisted treatment (MAT) and telemedicine options.

Happy Holidays,

Mylynn

***HHS highlights Office for Civil Rights' ongoing response to the opioid crisis, while implementing the 21st Century Cures Act

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) today launched an array of new tools and initiatives in response to the opioid crisis, while implementing the 21st Century Cures Act (Public Law 114-255). OCR continues its work to ensure that patients and their family members can get the information they need to prevent and address emergency situations, such as an opioid overdose or mental health crisis. At the same time, these tools and initiatives also fulfill requirements of the 21st Century Cures Act to ensure that the healthcare sector, researchers, patients, and their families understand how the Health Insurance Portability and Accountability Act (HIPAA) protects privacy and helps improve health and healthcare nationwide.

Highlights of these actions include:

- Two new HIPAA webpages focused on information related to mental and behavioral health, one for professionals and another for consumers. These webpages reorganize existing guidance to make it more user-friendly and provide a one-stop resource for our new guidance and materials. This guidance is an important step forward in clarifying the circumstances under which HIPAA permits a covered entity to disclose information to family members and caregivers.
    - For consumers: https://www.hhs.gov/hipaa/for-individuals/mental-health/index.html
    - For professionals: https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html
- These webpages contain new HIPAA guidance on sharing information related to mental health and substance use disorder treatment with a patient's family, friends and others involved in the patient's care or payment for care. The new information includes: a package of fact sheets; an infographic; decision charts, including materials specifically tailored to the parents of children who have a mental health condition; and scenarios that address sharing information when an individual experiences an opioid overdose.
- New collaboration with partner agencies within HHS to identify and develop model programs and materials for training healthcare providers, patients, and their families regarding permitted uses and disclosures of the protected health information of patients seeking or undergoing mental health or

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substance use disorder treatment, and to develop a plan to share the programs and materials with professionals and consumers.

- Updated guidance on HIPAA and research, as called for in the Cures Act: https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html
- Launch of a working group to study and report on the uses and disclosures under HIPAA of protected health information for research purposes. The working group will include representatives from relevant federal agencies as well as researchers, patients, healthcare providers, and experts in healthcare privacy, security, and technology. The working group will release a report addressing whether uses and disclosures of PHI for research purposes should be modified to facilitate research while protecting individuals' privacy rights.

For additional information on HIPAA, visit: https://www.hhs.gov/hipaa/

Mylynn Tufte, MBA, MSIM, BSN
State Health Officer
North Dakota Department of Health
600 E. Boulevard Ave. Dept. 301
Bismarck, ND 58505
W: 701-328-2372

NORTH DAKOTA
DEPARTMENT *of* HEALTH

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3-25-19

MEMORANDUM

TO: North Dakota Rural Health Learning Collaborative State Team
FROM: Sonia Pandit, Senior Policy Analyst
SUBJECT: Teleprescribing for Controlled Substances, Including Drugs for Opioid Addiction Treatment
DATE: December 1, 2017
CC: Lauren Block, Program Director; Sandra Wilkniss, Program Director

This memo responds to a request from the North Dakota state team regarding examples of states that allow providers to prescribe controlled substances, including drugs used for medication-assisted treatment (MAT) such as buprenorphine, via telemedicine.

State Law Landscape
The ability of providers to prescribe controlled substances via telemedicine varies among states. While some states explicitly prohibit the prescribing of controlled substances via telemedicine, there are other states that allow it, are silent, or provide specific conditions for allowance or prohibition (*e.g.*, cannot be used in connection with treatment of chronic nonmalignant pain). Furthermore, some state laws describe specific teleprescribing standards whereas others defer to the state Boards of Medicine.

Delaware
This year, Delaware implemented a regulation allowing opioid prescribing via telemedicine for addiction treatment programs offering MAT that have received a Division of Substance Abuse and Mental Health waiver to use telemedicine through the Division's licensure or renewal process. Attached is a copy of the proposed regulation. Relevant language regarding telemedicine is on page 23 and below:

> "No opioid prescribing is permitted via telemedicine with the exception of addiction treatment programs offering medication assisted treatment that have received a Division of Substance Abuse and Mental Health (DSAMH) waiver to use telemedicine through DSAMH's licensure or renewal process as outlined in 16 DE Admin. Code 6001 Substance Abuse Facility Licensing Standards Sec. 4.15. All other controlled substance prescribing utilizing telemedicine is held to the same standards of care and requisite practice as prescribing for in-person visits."

Ohio
This year, the Ohio Medical Board adopted new rules for telemedicine prescribing of drugs and controlled substances, allowing providers to prescribe drugs via telemedicine without conducting an in-person examination. Effective March 23, 2017, the new rule 4731-11-09 and rule 7331-11-01 set forth the requirements a physician must follow when prescribing opioids via telemedicine in Ohio:

An Ohio physician may prescribe controlled substances via telemedicine, without an in-person exam, if the physician satisfies the nine steps outlined for prescribing non-controlled substances ***and*** when one of the following six situations exists:

- The patient is an "active patient" of a health care provider who is a colleague of the physician and the controlled substances are provided through an on call or cross coverage arrangement between the

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health care providers. "Active patient" is a defined term under the new rules and means that "within the previous twenty-four months the physician or other health care provider acting within the scope of their professional license conducted at least one in-person medical evaluation of the patient or an evaluation of the patient through the practice of telemedicine as that term is defined in 21 C.F.R. 1300.04, in effect as of the effective date of this rule."

- The patient is located in a DEA-registered hospital or clinic;
- The patient is being treated by, and in the physical presence of, an Ohio-licensed physician or health care practitioner registered with the DEA;
- The telemedicine consult is conducted by a practitioner who has obtained a DEA special registration for telemedicine;
- A hospice program physician prescribes the controlled substance to a hospice program patient in accordance with the board of pharmacy rules; or
- The physician is the medical director of, or attending physician at, an "institutional facility" (defined in rule 4729-17-01) and 1) the controlled substance is being provided to a person who has been admitted as an inpatient to or is a resident of an institutional facility, and 2) the prescription is transmitted to the pharmacy by a means that is compliant with Ohio board of pharmacy rules.

Virginia

In 2015, Virginia enacted a law updating provisions pertaining to use of telemedicine. Additionally, the Virginia Board of Medicine published Telemedicine Guidelines to instruct practitioners on the use of telemedicine. The guidelines address establishing a valid practitioner-patient relationship, licensure, evaluation and treatment, informed consent, medical records, privacy and security of patient information, and remote prescribing. Guidelines for remote prescribing and controlled substances are noted below:

- **Remote Prescribing & Controlled Substances.** Virginia physicians may prescribe medications via telemedicine (i.e., remote prescribing). Doing so is at the discretion of the physician, provided the prescribing is consistent with standards of care and lists the direct contact information of the prescriber (or prescriber's agent) on the prescription itself. Regarding controlled substances, prescriptions must comply with requirements set forth in Va. Code §§ 54.1-3408.01 and 54.1-3303(A). Physicians may prescribe Schedule VI medication via telemedicine when a doctor-patient relationship is established using face-to-face, two-way real-time communications services or store-and-forward technologies when all of the following conditions are met:
    - The patient has provided a medical history that is available for review by the prescriber;
    - The prescriber obtains an updated medical history at the time of prescribing;
    - The prescriber makes a diagnosis at the time of prescribing;
    - The prescriber conforms to the standard of care expected of in-person traditional exams including the use of diagnostic testing or physical examination, via condition-appropriate peripheral devices;
    - The prescriber is licensed in Virginia and authorized to prescribe;
    - If the patient is enrolled in a health plan, the prescriber is credentialed by the health plan as a participating provider and the prescribing meets the plan's qualifications for reimbursement; and
    - Upon request, the prescriber provides medical records from the consultation to patients or their primary care physicians in a timely manner.

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West Virginia

In March 2016, West Virginia Gov. Earl Ray Tomblin signed into law, (HB 4463) implementing a variety of telemedicine practice standards and remote prescribing rules in the state. Remote prescribing without a prior in-person exam is permitted, including prescriptions for controlled substances, subject to certain limitations.

- A physician who practices medicine to a patient solely through the utilization of telemedicine technologies may not prescribe to that patient any Schedule II controlled substances.
- A physician may not prescribe any pain-relieving controlled substance listed in Schedules II through V as part of a course of treatment for chronic non-malignant pain solely based upon a telemedicine encounter.

The statute may require the WV Board of Medicine to rewrite some regulations to comply with state law and/or add a level of specificity. However, the Board had released a prior statement in which they defer to a physician's judgement as to whether or not to prescribe via telemedicine. The language is copied below:

> "Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters."

Oklahoma

Oklahoma Governor Mary Fallin signed into law SB 726, establishing new telemedicine practice standards, including explicitly allowing doctors to create valid physician-patient relationships via telemedicine without an in-person exam.

- **Telemedicine Prescribing.** A physician-patient relationship cannot be established via telemedicine or store and forward technologies for the purpose of prescribing opiates, synthetic opiates, semisynthetic opiates, benzodiazepine or carisprodol, but may be used to prescribe opioid antagonists or partial agonists.

Oklahoma already has medical board regulations (Okla. Admin. Code r. 435:10-7-13) and a position statement on the practice of telemedicine, and the new law may potentially require the Oklahoma Board of Medicine to rewrite some of its existing guidance to the extent it conflicts with the controlling provisions of the new statute.

Indiana

Former Indiana Gov. Mike Pence signed into law, on March 21, 2016, a HB 1263 regarding telemedicine practice standards and remote prescribing. Under the law, an Indiana provider may prescribe controlled substances via telemedicine, without an in-person exam, if the provider satisfies the conditions outlined for non-controlled substances *and* the following conditions are met:

- The prescription is not for an opioid, unless the opioid is a partial agonist that is used to treat or manage opioid dependence.
- The prescriber maintains a valid controlled substance registration.

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- The prescriber meets the conditions set forth in the federal Ryan Haight Act.
- The patient has been examined in-person by a licensed Indiana health care provider and the licensed health care provider has established a treatment plan to assist the prescriber in the diagnosis of the patient.
- The prescriber has reviewed and approved that treatment plan and is prescribing for the patient pursuant to that treatment plan.
- The prescriber complies with Indiana's INSPECT prescription drug monitoring program.
- The prescription for a controlled substance is prescribed and dispensed in accordance with Indiana Code 35-48-7.

Michigan

Michigan Governor Rick Snyder signed into law SB 213, clarifying that health professionals in Michigan may prescribe controlled substances via telemedicine without an in-person examination if the following conditions are met:

- The health professional is a prescriber acting within the scope of his or her practice in prescribing the drug; and
- If the health professional is prescribing a controlled substance, he or she meets the requirements applicable to that health professional for prescribing a controlled substance.

The law also requires the prescriber to comply with both of the following provisions:

- If the health professional considers it medically necessary, he or she must provide the patient with a referral for other health care services geographically accessible to the patient, including emergency services; and
- After providing a telehealth service, the health professional, or a health professional acting under the delegation of another health professional, must make himself or herself available to provide follow-up health care services to the patient or refer the patient to another health professional for follow-up health care services.

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Bonnie Storbakken

From:	Jack McDonald <jackmcdonald@wheelerwolf.com>
Sent:	Wednesday, February 7, 2018 5:05 PM
To:	Bonnie Storbakken
Cc:	Jack McDonald
Subject:	Administrative Rules
Attachments:	AHIPs Comments on Proposed Chapter 50-02-15 - Telemedicine Final.docx

Bonnie: Attached – and hopefully sent now to the correct address - are some comments from America's Health Insurance Plans (AHIP) concerning the ND Board of Medicine's proposed telemedicine administrative rules, and particularly proposed Section 50-02-05-01 concerning the provider-patient relationship. Would you please bring these comments to the attention of your committee that will be considering the proposed rules Feb. 9. Let me know if you have any questions. Thank you for your consideration.

Jack McDonald
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Box 1776
Bismarck, ND 58502-1776
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jackmcdonald@wheelerwolf.com

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America's Health
Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

February 7, 2018

Bonnie Storbakken
Executive Secretary
ND Board of Medicine
418 E. Broadway, Ste. 12
Bismarck, ND 58501

Re: AHIP's Comments on Proposed Section 50-02-05-01 - Telemedicine

Dear Executive Secretary Storbakken:

I am writing on behalf of America's Health Insurance Plans (AHIP) to raise concerns we have about the North Dakota Board of Medicine's proposed new Section 50-02-05-01 of the North Dakota Administrative Code regarding telemedicine definitions. AHIP is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. Our members are committed to providing consumers with affordable products that offer a broad range of robust provider networks of quality, cost-efficient providers.

As an industry, we are supportive of efforts to improve access to quality care. As technology has evolved in recent years, telemedicine has become an option for achieving this goal by removing traditional barriers to health care delivery such as distance, mobility, and time constraints.

As North Dakota works to create a regulatory scheme that will govern this model of health care delivery, we would like to raise a concern that we have regarding the current draft of proposed Section 50-02-05-01, which requires that valid provider-patient relationship be established through an initial in-person or audio-video evaluation. This requirement presumes that every service provided via electronic means, e.g., telemedicine, would have the provider evaluating the person through an audio or video means before performing the service. This requirement would also place a significant delay and operational constraint on a significant number of medical services.

For example, many pathology and radiology examinations are done through telemetry, without the providers establishing a provider-patient relationship, or meeting the person. We believe that

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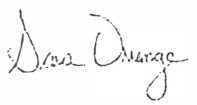
patients, providers, and health plans should have choice and flexibility regarding the use of telemedicine services. Mandating that a valid provider-patient relationship can only be established through an initial in-person or audio-video evaluation is an overly prescriptive standard that becomes an artificial barrier to care.

This standard also fails to consider the evolving nature of telemedicine technology, and it limits a patient's options when deciding on the best course of action to obtain health care. There are circumstances where telemedicine services provided via audio-only consultations are appropriate. The American College of Physicians has also noted that providers providing health care services via telemedicine can also establish a valid provider-patient relationship by consulting with another physician who does have a relationship with the patient or oversees his or her care.[1] Patients, their providers, and health plans are best positioned to make these types of determinations and need to have the flexibility to do so.

We appreciate the Board's efforts to develop regulations governing telemedicine that strike the right balance between patient safety and access. Thank you for the opportunity to provide feedback regarding proposed Section 50-02-05-01. If you have any questions, please do not hesitate to contact me at sorrange@ahip.org or (703-887-5285).

Sincerely,



Sara Orrange
Regional Director, State Affairs
America's Health Insurance Plans

[1] Doherty, Robert B., "Must telemedicine disrupt the patient-doctor relationship?" ACP Internist, January 2016. Accessed at https://acpinternist.org/archives/2016/01/washington.htm.

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Definition of Telemedicine: Some direct to consumer (DTC) models utilize what they refer to as *"enhanced audio with asynchronous store-and-forward".* Essentially what this means is the patient fills out an online medical information questionnaire, and that information is forwarded electronically to the DTC practitioner. Thus, the term.

Language in the definition of telemedicine might include: "asynchronous store-and-forward does not include patient-supplied medical information."

"Patient-Licensee Relationship": a) under 3) would be written to suggest that the in-person equivalency only applies to 3). Because In-person equivalency should apply also to 2), the paragraph identification should be modified. Also, i) seems that should be free standing and not under 3).

"Standard of Care and Professional Ethics": b) *"A licensee practicing telemedicine shall verify the identity of the patient seeking care; and disclose the identity and licensure status of any licensee providing medical services to the patient. The patient must have the ability to verify the identity and licensure status of any licensee providing telemedicine services to the patient."* While the intent of this language maybe directed at DTC programs for first time visits, it probably is worth considering how this would impact practitioners providing care through established, facility-based telemedicine programs in the state. For example, how would this apply to a hospital-based specialist examining a patient in a clinic or critical access hospital in the state?

c) "... or by a provider designated by the licensee to act temporarily in the licensee's absence." This likely refers to "on-call" situations. This language makes clear the "licensee" who conducted the examination must designate the on call provider. Some DTC models provide that the patient self-select the DTC provider to provide care. So, when the patient self supplies the medical information on the company's website, they agree to terms and conditions, including a provision designating the company's DTC practitioners as their on call practitioner. If this loophole is to be closed, this language along with any other language or policy needs to specifically indicate that only the patient's practitioner may designate the on call arrangement.

Prescribing: This language may be stronger than Federal law, which may be the intention.

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ATTACHMENT 3

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MEDICAID MEDICAL POLICY
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 85 (6-9-2010)

Medicaid Policy Number (This number will be generated by Medical Services.)	Date Policy was Last Reviewed
NDMP-2012-0007	07-27-2017

Title
Telemedicine Services

Effective Date
8-1-2012

Revision Date(s)
7-2-2013; 01-14-2015; 05-31-2017; 07-27-2017

Replaces
Medicaid Coding Guideline; General Provider Manual information

Cross References

Description
Telemedicine is the use of interactive audio-video equipment to link practitioners and patients at different sites. Telemedicine involves two collaborating provider sites: an "originating site" and a "distant site". The client/patient is located at the originating site and the practitioner enrolled with ND Medicaid is located at the distant provider site to provide those professional services allowed/reimbursed by ND Medicaid.

Scope
Medical policies are systematically developed guidelines that serve as a resource for ND Medicaid staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the ND Medicaid program.

Policy
Telemedicine/Telehealth services via interactive audio-video equipment.

Policy Guidelines

1. To qualify as a professional service, actual visual contact (face-to-face) must be maintained between the practitioner and patient.
2. Services allowed/reimbursed by ND Medicaid include: New and established Office and Other Outpatient E/M services; Psychiatric diagnostic evaluation; Individual psychotherapy; Pharmacologic management; Speech Therapy, individual; Initial inpatient telehealth consultations.
3. Practitioners must append modifier GT to identify a service as being performed via telemedicine.
4. All services must be medically appropriate and necessary with supporting documentation of the service must be included in the patient's clinical medical record.
5. The originating and distant sites of telemedicine services cannot be in the same facility or community. The distant site must be a sufficient distance from the originating site to provide services to patients who do not have readily available access to such specialized services allowed/reimbursed by ND Medicaid via telemedicine.
6. A designated room at the originating site must have secure and appropriate equipment to ensure confidentiality, including camera(s), lighting, transmission and other needed electronics. Appropriate medical office amenities must be established in both the originating and distant sites. Skype or other unsecure web cam devices are not acceptable or allowed to be used for telehealth services.
7. Reimbursement will be made only to the distant practitioner during the telemedicine session. No reimbursement is allowed to a practitioner at the originating site if his/her sole purpose is the presentation of the patient to the practitioner at the distant site.

8. Reimbursement will be made to the originating site as a facility fee only in place of service office, inpatient hospital, outpatient hospital, or skilled nursing facility/nursing facility. There is no additional reimbursement for equipment, technicians or other technology or personnel utilized in the performance of the telemedicine service.

Benefit Application

- Coverage is limited to reimbursement for services identified by this policy via interactive audio-video telemedicine.
- Reimburs

ement is made for services provided by licensed professionals enrolled with ND Medicaid and within the scope of practice per their licensure only. • All service limits set by ND Medicaid for psychiatry, speech therapy,

and individual medical nutrition therapy apply to telemedicine services.

- Requires the presence of an individual to assist with establishing and maintaining the connection to the distant practitioner and have the ability to resond to the needs of the member.
- Out of State requests for telemedicine services require prior authorization. The services must be in compliance with the Out of State Program requirements.

Rationale Source

42 CFR 410.78 - Telehealth services - http://cfr.vlex.com/vid/410-78-telehealth-services-19805820;
CMS Issues Final Regulations on Telemedicine Credentialing Conditions of Participation - http://www.bricker.com/publications-and-resources/publications-and-resources-details.aspx?Publicationid=2165;
Telemedicine - Medicaid.gov - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

Code of Federal Regulations Citation(s)

42 CFR 410.78 - Telehealth services.

CODES	NUMBER	DESCRIPTION
CPT®	99201-99215	New and established Office and Other Outpatient E/M services
	90785	Interactive complexity (list separately in addition to the code for primary procedure)
	90791	Psychiatric Diagnostic Evaluation
	90792	Psychiatric Diagnostic Evaluation with medical services
	90832	Psychotherapy, 30 minutes with patient and/or family member
	90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
	90834	Psychotherapy, 45 minutes with patient and/or family member
	90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
	90837	Psychotherapy, 60 minutes with patient and/or family member
	90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
	92507	Speech Therapy, Individual
	99307-99310	Subsequent nursing facility care services

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	G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
	G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
	G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
Applicable Modifier(s)	GT	Via interactive audio and video telecommunication systems
ICD-9 Procedures(s)	N/A	
ICD-9 Diagnosis(es)		Must support medical necessity and coded to the highest specificity.
Applicable Revenue Codes(s)	780	Telemedicine – Facility charges related to the use of telemedicine
HCPCS Code(s)	Q3014	Telehealth originating site facility fee
Type of Service	Medicine	As listed in the Medicine section of CPT®.
Place of Service	02	Telehealth - The location where health services and health related services are provided or received, through a telecommunication system *(effective 01/01/2017)*
	11	Office
	21	Inpatient Hospital
	22	Outpatient Hospital
	31	Skilled Nursing Facility
	32	Nursing Facility
	53	Community Mental Health Center

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CENTER FOR TELEHEALTH & e-HEALTH LAW

Telemedicine: Prescribing and the Internet

Christa Natoli
Director of the Center for Telehealth & e-Health Law and Program Director for the National Telehealth Resource Center

Natoli, Christa. "Telemedicine: Prescribing and the Internet." *Center for Telehealth & e-Health Law* (2011).

ABSTRACT

The author provides an overview of state laws as they relate to prescribing within the field of telemedicine. This report analyzes the various requirements necessitated by state medical boards before a physician is permitted to prescribe medication to a patient. The conclusions established within this paper have been verified by each state medical board.

Telehealth Overview

Advancements in medicine and technology have transformed the way health care is delivered to patients. However, laws governing these interactions have not evolved at the same pace, leaving many legal and regulatory questions unanswered in the area of Internet prescribing and telemedicine. To best analyze this issue, we must examine the laws that govern physicians prescriptive authority.

These laws are found at the state level because Article X of the Constitution grants medical boards the authority to regulate the health, safety, and welfare of their citizens. Although the federal government has the authority to establish specific, professional requirements for doctors under the purview of the Supremacy Clause, there is a strong legal presumption against federal preemption of state prescribing laws. As a result, prescribing regulations vary state-by-state.

However, even though these laws are governed at the state level and vary state-by-state, there are consistent legal issues within the law that determine a state's position on prescribing over the Internet. These two legal issues include the physical examination requirement and the pre-existing physician-patient relationship requirement.

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CTEL
CENTER FOR TELEHEALTH & e-HEALTH LAW

Pre-existing Physician-Patient Relationship

Many states require that a patient have a pre-existing relationship with their doctor before the physician is able to prescribe medication to a patient through telemedicine. In most states, if the patient does not have a pre-existing physician-patient relationship with the physician, the physician providing the telemedicine treatment is required to examine the patient in-person. For the most part, this law only applies to those states that do not allow for the examination to take place electronically.

Physical Examination

In order to prescribe medication to a patient, a physician is required to conduct a medical examination of that patient. This is a standard of care that is accepted by the medical community. Traditionally, before the onset of telemedicine, examinations took place in-person where the practitioner physically examined the patient face-to-face. As medicine and technology advanced, physicians were presented with new tools, such as telemedicine, that would allow a practitioner to conduct that examination electronically.

However, state laws governing these interactions were unclear as to whether a physician was legally permitted to examine the patient over the Internet, through telemedicine, and then prescribe medication to that patient.

The confusion is rooted in the fact that the laws governing these telemedicine interactions were written decades before telemedicine was even conceptualized. In efforts to bring clarity to this situation, a small group of state legislators and state medical boards began analyzing whether telemedicine examinations met the medical standard or care requirement. That is, will the examination result in a proper evaluation, diagnosis and treatment plan for that patient?

Still, to this day, very few states have specific language addressing the issue of telemedicine and Internet prescribing. For those states that do not have specific telemedicine and Internet prescribing laws, states refer physicians to their state's statute or board policies that generally speak to a physician's right to prescribe.

Presently, there are 41 states and 1 territory (Puerto Rico) that require a physician to conduct an in-person or face-to-face physical exam of the patient before the physician is

permitted to prescribe medication using telemedicine. This means patients living in remote and rural areas may be required to travel hundreds of miles to receive a physical exam in order to be eligible for treatment by telemedicine in the future. Many argue that this physical examination requirement defeats the purpose of telemedicine – a tool that is supposed to virtually bridge the gap between patient and provider.

Electronic Examination

However, there are a handful of states that specifically allow telehealth practitioners to conduct medical examinations using telemedicine technologies. These states require that the practitioner keep with the standard of care when conducting the electronic examination.

According to those state medical boards that allow for electronic examinations, practitioners should not prescribe medication to a patient unless they believe the electronic examination meets the standard of care within the medical community.

For example, if a physician believes that the patient's medical condition warrants an in-person examination, the practitioner is required to physically exam that patient before prescribing medication or administering treatment.

Medical Questionnaires

While some states allow for an electronic examination, almost all states do not allow for that examination to take place through the use of a medical questionnaire. State medical boards adhere to the belief that the administration of a on-line medical questionnaire as the sole basis for prescribing does not keep with the accepted standard of care.

In recent years, state medical boards have seen a rapid rise in illegitimate telemedicine operations by both new and established companies. Generally, these telemedicine business models do not offer a means to physically exam the patient. Rather the model solely relies on the patient to provide the physician with their own patient data and medical history, through the utilization of an on-line form. To date, there are 28 states that explicitly prohibit the use of an on-line medical questionnaire as the sole means for gathering patient data for means of prescribing medication.

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Establish Appropriate Follow-up Care

In addition to ensuring that a physician conducts a proper medical exam, 13 states require a physician to establish appropriate follow-up care with the patient after prescribing medication - four of those states allow for an examination to take place electronically.

Conclusion

Generally, states are conservative in what they view to be an appropriate physical examination requirement. However, many state legislators and medical boards assert that they are not trying to impede the advancement of telemedicine but rather ensure that patients receive access to quality health care services.

According to Dr. Jean Sumner, Georgia State Medical Board, "Access to no care at all is better than access to poor care. We are at the very start of telemedicine and we have the opportunity to shape this industry and make it great."

DISCLAIMER

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Information contained in this report is current up to the date listed on the report. Note that the information is subject to change following action taken by a state's legislature, state agencies, state medical boards, or other applicable state government agency or body. CTeL will make every effort to provide the most current information.

The views and opinions expressed in the forgoing publication are solely those of the author and do not necessarily represent the views and opinion of the Center for Telehealth & e-Health Law, its Board of Directors, or its staff.

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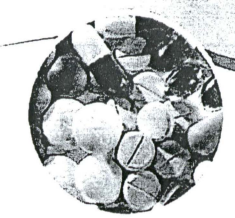

Public Health Law

Office for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention

Prescription Drug Physical Examination Requirements

The United States is in the midst of an unprecedented epidemic of prescription drug overdose deaths.[1] More than 41,000 people died of drug overdoses in 2011, and most of these deaths (22,810) were caused by overdoses involving prescription drugs.[2] Three-quarters of prescription drug overdose deaths in 2011 (16,917) involved a prescription opioid pain reliever (OPR), which is a drug derived from the opium poppy or synthetic versions of it such as oxycodone, hydrocodone, or methadone.[3] The prescription drug overdose epidemic has not affected all states equally, and overdose death rates vary widely across states.

States have the primary responsibility to regulate and enforce prescription drug practice. Although state laws are commonly used to prevent injuries, and their benefits have been demonstrated for a variety of injury types,[4] little information is available on the effectiveness of state statutes and regulations designed to prevent prescription drug abuse and diversion. This menu is a first step in assessing laws on physical exam requirements by creating an inventory of state legal strategies in this domain.

Introduction

This resource includes physical examination laws if they require a licensed practitioner to examine the patient before prescribing a medication. In this menu, "practitioner" refers to a physician, dentist, pharmacist, physician's assistant, nurse practitioner, or any other person licensed, registered, or permitted to prescribe, dispense, distribute, or administer a controlled substance. Laws are included

[1] For the purpose of this document, "overdose death" refers to death resulting from either intentional overdose or accidental overdose, which could be caused by a patient being given the wrong drug, taking the wrong drug in error, or taking too much of a drug inadvertently. CDC's National Center for Injury Prevention and Control also refers to overdose as a drug poisoning, which may or may not result in death.

[2] Centers for Disease Control and Prevention, Wide-ranging Online Data for Epidemiologic Research (WONDER) Database (2012) http://wonder.cdc.gov.

[3] *Id.*

[4] Schieber RA, Gilchrist J, & Sleet DA. *Legislative and Regulatory Strategies to Reduce Childhood Injuries*, 10 FUTURE CHILD. 1, 111–36 (2000).

only if they expressly require an examination or evaluation. Laws requiring a practitioner-patient relationship or use of a valid prescription are included only if the definition of practitioner-patient relationship or valid prescription expressly requires a physician examination.[5] Forty-one states[6] and the District of Columbia have one or more laws that require a prescriber or dispenser to ensure that prescriptions for medications are based on an examination of the patient.[7] States with these laws may require a physical examination as part of *prescribing* regulations, or may prohibit pharmacists and physicians from *dispensing* certain types of drugs if there is doubt the drugs were prescribed following a physical exam. Some states limit the applicability of the laws to certain drug types, apply laws only in certain circumstances, or contain exceptions to examination requirements.[8] Most states[9] and the District of Columbia have multiple physical examination laws and thus fall under multiple categories.

Type of Examination Required

Most examination laws[10] require a "physical examination" as the basis for prescribing and dispensing a controlled substance.

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[5] Some states, such as Missouri, have come to define the patient-practitioner relationship to include a physical examination through judicial interpretation. *See State v. Kane*, 586 S.W.2d 812 (App. E.D. 1979) (defining "patient-practitioner" as used in MO. ANN. STAT. § 195.204 to mean "first making some attempt to determine physical condition or health needs of person for whom he writes the prescription." *Id.* Those statutes are not included in this report.

[6] Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, and Washington.

[7] The nine states (Colorado, Illinois, Kansas, Michigan, New York, South Dakota, West Virginia, Wisconsin, and Wyoming) that do not have physical examination requirements according to this assessment likely have a physical examination requirement that may be incorporated into state law through a general provision requiring adherence to medical professional and ethical standards. The research on which this menu is based was limited to express provisions in statute or regulation.

[8] In this menu, the first effective dates of the specific provisions referenced are cited as "[legal citation] (eff. [year])." Where dates were either not provided within the laws or were unclear due to multiple revisions, this fact is cited as "[legal citation] (eff. date unclear, [estimated year])."

[9] Thirty-seven states: Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, and Washington.

[10] Thirty-four states and the District of Columbia. *See, e.g.*, ALA. ADMIN. CODE r. 540-X-9-.11 (eff. 2000); ALASKA ADMIN. CODE tit. 12, § 40.967 (eff. 2000); ARIZ. REV. STAT. ANN. §§ 32-1401(27)(ss) (eff. 2000), -1501(31)(ww) (eff. 2003), 1854(48) (eff. 2000); 060.00.1 ARK. CODE R. § 2 (eff. date unclear); CONN. GEN. STAT. ANN. § 20-613a (eff. 2005); D.C. MUN. REGS. tit. 17, § 4616 (eff. 2012); DEL. CODE ANN. tit. 16, § 4744(c)(1) (eff. 2008); FLA. STAT. § 458.3265 (eff. 2011); GA. COMP. R. & REGS. 360-3-.02 (eff. date unclear); HAW. REV. STAT. ANN. § 329-1 (eff. 2008); 844 IND. ADMIN. CODE 5-4-1 (eff. 2003); IOWA ADMIN. CODE r.653-13.2(148,272C) (eff. date unclear); 201 KY. ADMIN. REGS. 8:540 (eff. 2012); LA. ADMIN. CODE tit. 46, pt. XLV, § 6921 (eff. 1997); 02-313 ME. CODE R.Ch. 21, § III (eff. 2010); MINN. R. 6500.0600 (eff. 1988); 30-17-2635 MISS. CODE R. §7.1 (eff. 2012); MO. REV. STAT. § 334.108 (eff. 2011); NEB. ADMIN. CODE § 172, Ch. 90, § 008 (eff. date unclear); NEV. ADMIN. CODE § 639.945 (eff. date unclear); N.H. REV. STAT. ANN. §318-B:1 (eff. 2011); N.J. ADMIN. CODE § 13:35-7.6(a) (eff. 2003); N.M. CODE R. § 16.10.8 (eff. 2003); 21 N.C. ADMIN. CODE § 46.1801(b) (eff. 2003); N.D. CENT. CODE § 19-02.1-15.1 (eff. 2009); OHIO ADMIN. CODE 4731-11-03 (eff. date

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- **Indiana**
  "[A] physician shall not prescribe, dispense, or otherwise provide, or cause to be provided, any controlled substance to a person who the physician has never personally physically examined and diagnosed."[11]
- **South Carolina**
  Prior to prescribing a drug to an individual, a practitioner must "personally perform and document an appropriate history and physical examination . . . ."[12]

Sixteen states[13] and the District of Columbia[14] have laws that require an examination or evaluation that is deemed "appropriate" or some approximation of "sufficient," instead of or in addition to the physical examination laws.

- **California**
  Requires an "appropriate prior examination."[15]
- **Minnesota**
  Requires an "in-person examination" that is "adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment."[16]
- **New Jersey**
  When a practitioner prescribes a controlled substance, he or she must perform a physical examination "including an assessment of physical and psychological function, underlying or coexisting diseases or conditions, any history of substance abuse and the nature, frequency and severity of any pain."[17]

In some states dispensers are allowed to dispense prescriptions only if the prescription is prescribed by a practitioner who previously performed an adequate examination.

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unclear); OKLA. ADMIN. CODE § 435:10-7-11 (eff. 2005); 49 PA. CODE § 16.92(b)(1) (eff. 1986); R.I. GEN. LAWS § 21-28-3.24 (eff. 1974); S.C. CODE ANN. §§ 40-47-113 (eff. 1976); TENN. COMP. R. & REGS. 0880-02-.14(6)(e)(3)(i) (eff. 2001); 22 TEX. ADMIN. CODE § 170.3(a)(1), (7) (eff. 2007); UTAH ADMIN. CODE r. 156-37 (eff. date unclear); 18 VA. ADMIN. CODE § 85-20-25 (eff. date unclear); WASH. ADMIN. CODE §246-817-915 (eff. 2011).

[11] 844 IND. ADMIN. CODE 5-4-1 (eff. 2003).

[12] S.C. CODE ANN. §§ 40-47-113 (eff. 1976).

[13] *See, e.g.*, CAL. BUS. & PROF. CODE § 2242 (eff. 2000); CONN. AGENCIES REGS. § 21a-326-1 (eff. 1984); IDAHO CODE. ANN. § 54-1733; IOWA ADMIN. CODE r.650-16.2(153) (eff. date unclear); LA. REV. STAT. ANN. § 40:1238.4 (eff. 2007); MD. CODE REGS. 10.32.05.05 (eff. 2009); 234 MASS. CODE REGS. 9.05 (eff. date unclear); MINN. STAT. § 151.37 (eff. date unclear); 30-17-2635 MISS. CODE R. § 7.1 (eff. 2012); MO. CODE REGS. ANN. tit. 19§ 30-1.068 (eff. 2000); NEB. ADMIN. CODE § 172, Ch. 56, § 007 (eff. date unclear); NEV. ADMIN. CODE § 635.390 (eff. date unclear); N.J. ADMIN. CODE § 13:35-7.6 (eff. date unclear); N.M. CODE R. §16.5.57 (eff. date 2013); 22 TEX. ADMIN. CODE §§ 291.29 (eff. 2001); VT. STAT. ANN. tit. 18, § 9361 (eff. 2012).

[14] D.C. MUN. REGS. tit. 22-B, § 1300.7 (eff. 1986).

[15] CAL. BUS. & PROF. CODE § 2242 (eff. 2000).

[16] MINN. STAT. ANN. §§ 151.37 Subd. 2(d), (e) (eff. date unclear).

[17] N.J. ADMIN. CODE § 13:35-7.6 (eff. date unclear).

- **Missouri**
  "[p]rescriptions processed by any . . . pharmacy must be provided by a practitioner . . . who has performed a *sufficient physical examination* and clinical assessment of the patient."[18]

A few states simply require an examination before prescribing or dispensing controlled substances without giving specific standards for that examination.[19]

- **Montana**
  "[p]rescribing, dispensing or furnishing any prescription drug without a prior examination and a medical indication therefor," is unprofessional conduct.[20]

Applicability of Examination Requirement

Regardless of whether a state's physical examination law applies to prescribers or dispensers, and whether it requires a physical examination or more general examination or evaluation, the law might apply only to prescriptions for certain types of drugs or in specific circumstances.

Thirty-six states[21] and the District of Columbia[22] have physical examination laws that apply to prescriptions of all drug types or any prescription (includes controlled substances).

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[18] MO. CODE REGS. ANN. tit. 20, § 2220-2.020(11) (emphasis added) (eff. 2005).

[19] Ten states. *See, e.g.*, CAL. BUS. & PROF. CODE § 805.01 (eff. 2010); IDAHO ADMIN. CODE r. 23.01.01.315 (eff. 1999); IOWA ADMIN. CODE r. 650-16.3(153) (eff. date unclear); 201 KY. ADMIN. REGS. 20:057 (eff. 2012); MONT. ADMIN.R. 24.213.2301 (eff. 1998); NEB. ADMIN. CODE § 172, Ch. 120, § 010 (eff. date unclear); NEV. ADMIN. CODE §. 639.235 (eff. date unclear); N.J. ADMIN. CODE § 13:35-7.4 (eff. 2003); OR. REV. STAT. §677.190 (eff. date unclear); S.C. CODE ANN. § 40-47-965 (eff, date unclear).

[20] MONT. ADMIN .R. 24.213.2301(34) (eff. date unclear, prior to 1998).

[21] *See, e.g.*, ALA. ADMIN. CODE r. 540-X-9-.11 (eff. 2000); ALA. ADMIN. CODE r. 680-X-2-.33 (eff. 2006); ALASKA ADMIN. CODE tit. 12, § 40.967 (eff. date unclear); ARIZ. REV. STAT. ANN. §§ 32-1401(27)(ss), 32-1501(31)(ww), 32-1854(48) (eff. 2000); ARIZ. ADMIN. CODE § R4-23-110 (eff. 2000); ARK. CODE ANN. 17-92-1004(c) (eff. 2007); 070.00.7 ARK. CODE R. § 07-00-0009 (eff. 2007); CAL. BUS. & PROF. CODE § 805.01 (eff. 2010); CONN. GEN. STAT. ANN. § 20-613a (eff. 2005); CONN. AGENCIES REGS. § 21a-326-1(c) (eff. 1984); DEL. CODE ANN. tit. 16, § 4744(c)(1) (eff. 2008); FLA. STAT. ANN. § 465.023(1)(h) (eff. 2009); GA. CODE ANN. § 43-34-25 (eff date. unclear); HAW. REV. STAT. § 329-41 (eff. 2008); IDAHO CODE ANN. § 54-1733(1) (eff. 2006); 844 IND. ADMIN. CODE 5-4-1 (eff. 2003); IOWA CODE ANN. §§ 155A.27, 155A.13B (eff. 2009); KY. REV. STAT. ANN. § 218A.140(3) (eff. 2007); LA. ADMIN CODE. tit. 46, PT. XLVII, § 4513 (eff. date unclear); MD. CODE REGS.10.32.05.05 (eff. 2009); 234 MASS. CODE REGS. 9.05 (eff. date unclear); MINN. STAT. ANN. § 151.34 (eff. date unclear); 30-17-2635 MISS. CODE R. § 7.1 (eff. 2012); MO. CODE REGS. ANN. tit. 20, §§ 2220-2.020(9)(K), (11) (eff. 2005); NEB. ADMIN. CODE § 172, Ch. 56, § 007 (eff. date unclear); NEV. ADMIN. CODE § 639.945 (eff. 2001); N.H. REV. STAT. ANN. §§ 318-B:1(XXVI-a) (eff. 2011), -B:2(V)(e), -B:2(XII-b), -B:2(XII-c), -B:2(XII-e)(eff.2013), 329:1-c (eff. 2009), 329:17(VI)(I) (eff. 2009); N.J. ADMIN. CODE § 13:35-7.6(a) (eff. 2003); N.M. CODE R. § 16.10.8.8(L) (eff. 2001); 21 N.C. ADMIN. CODE 46.1806 (eff. 2003); N.D. CENT. CODE § 19-03.1-22.4 (eff. 2009); OHIO ADMIN. CODE 4730-2-07(B) (eff. 2007); OHIO ADMIN. CODE 4731-11-09(A) (eff. 1999); OKLA. ADMIN. CODE § 535:15-3-13(d) (eff. 2005); OR. REV. STAT. § 677.190 (eff. date unclear); 49 PA. CODE § 16.92(b)(1) (eff. 1986); S.C. CODE ANN. § 40-47-113 (eff. 2006); S.C. CODE ANN. § 44-117-340 (eff. 2007); TENN. COMP. R. & REGS. 1050-02-.13 (eff. 2001); 22 TEX. ADMIN. CODE § 190.8(1)(L) (eff. date unclear, 2003 or later); VT. STAT. ANN. tit. 18, § 9361 (eff. 2012); VA. CODE ANN. § 54.1-3303 (eff. 2000).

[22] D.C. MUN. REGS. tit. 22-B, § 1300.7 (eff. 1986).

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- **Mississippi**
  "[P]roper prescribing and legitimate medical practice require . . . an appropriate physical . . . before prescribing any medication for the first time."[23]
- **Arkansas**
  An in-person physical examination "prior to the issuance of any prescription is required in order to establish a valid prior patient-practitioner relationship for purposes."[24]

A smaller number of states[25] and the District of Columbia[26] have laws that apply when using drugs or controlled substances for pain management treatment.

- **Oklahoma**
  Requires a physical examination where a physician prescribes medication to "treat a patient's intractable pain."[27]
- **Tennessee**
  Requires the physical examination prior to prescribing to include "an assessment and consideration of the pain" for which the controlled substance is being prescribed.[28]

Florida not only has physical examination laws for the prescribing and dispensing of all drugs, but also has physical examination laws specifically for pain management drugs.[29]

Fourteen states[30] have laws that apply only to specific controlled substances, schedules, or treatment of specific conditions.

- **Washington**
  A nurse practitioner must "obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic noncancer pain."[31]

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[23] 30-17-2635 MISS. CODE R. §7.1 (eff. 2012).
[24] 070.00.7 ARK. CODE R. § 07-00-0009 (eff. 2007).
[25] Thirteen states. *See, e.g.*, ALA. ADMIN. CODE r. 540-X-4-.08 (eff. 2000); FLA. STAT. § 458.3265 (eff. 2011); FLA. STAT. § 459.0137 (eff. 2011); FLA. ADMIN. CODE r. 64B8-9.013 (eff. 2010); IOWA ADMIN. CODE r. 653-13.2(148,272C) (eff. date unclear); 201 KY. ADMIN. REGS. 5:130 (eff. 2012); LA. REV. STAT. ANN. § 40:2198.12 (eff. 2005); LA. ADMIN. CODE tit. 46, pt. XLV, § 6921(A)(1) (eff. 1997); 02-313 ME. CODE R. Ch. 21, § III (eff. 2010); N.J. ADMIN. CODE § 13:35-7.6 (eff. date unclear); N.M. ADMIN. CODE 16.5.57 (eff. date unclear); OHIO ADMIN. CODE 4731-21-02 (eff. 2008); OKLA. CODE 435:10-7-11 (eff. 2005); OKLA. CODE 510:5-9-2 (eff. 1999); TENN. COMP. R. & REGS. 0880-02-.14 (eff. date unclear); 22 TEX. ADMIN. CODE § 170.3 (eff. 2001); WASH. ADMIN. CODE § 246-817-915 (eff. 2011).
[26] D.C. MUN. REGS. tit. 17, § 4616 (eff. 2012).
[27] OKLA. ADMIN. CODE § 510:5-9-2 (eff. 1999).
[28] TENN. COMP. R. & REGS. 0880-02-.14 (eff. date unclear).
[29] FLA. STAT. § 458.3265 (eff. 2010); FLA. STAT. § 459.0137 (eff. 2011); FLA. ADMIN. CODE r. 64B8-9.013 (eff. 2010).
[30] *See, e.g.*, 060.00.1 ARK. CODE R. § 2 (eff. date unclear); IOWA ADMIN. CODE r. 650-16.7(153) (eff. date unclear); IOWA ADMIN. CODE r. 653-23.1(272(C)) (eff. date unclear); 201 KY. ADMIN. REGS. 25:090 (eff. 2012); 201 KY. ADMIN. REGS. 9:260 (eff. 2012); LA. ADMIN CODE. tit. 46, pt. XLV, § 6921 (eff. 1997); MINN. STAT. §151.37 (eff. date unclear); MISS. CODE ANN. § 41-29-137 (eff. 2009)); NEV. ADMIN. CODE § 636.2882 (eff. date unclear); N.J. ADMIN. CODE § 13:35-7.4 (eff. 2003); OHIO ADMIN. CODE 4731-11-03 (eff. date unclear); OKLA. ADMIN. CODE § 510:5-9-2 (eff. 1999); R.I. GEN. LAWS §21-28-3.24 (eff. 1956); S.C. CODE ANN. § 44-53-360 (eff. date unclear); UTAH ADMIN. CODE r.156-37 (eff. date unclear); WASH. ADMIN. CODE § 246-840-467 (eff. 2011).
[31] WASH. ADMIN. CODE § 246-840-467 (eff. 2011).

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- **Minnesota**
  Provides a list of substances, including certain schedules, for which "[a] prescription or drug order . . . is not valid, unless it can be established that the prescription or order was based on a documented patient evaluation, including an examination."[32]
- **Iowa**
  In addition to having regulations that concern pain management and prescribing controlled substances for any condition, sets an exam requirement for dentists to renew or refill emergency prescriptions for Schedule II controlled substances.[33]

Application with Reference to a Patient-Practitioner Relationship

Many states and the District of Columbia[34] have laws that require a physical examination by reference to a practitioner-patient relationship.[35] Some states do this by requiring a relationship between the practitioner and the patient, and then provide a definition of "practitioner-patient" or "physician-patient" (or some other similar combination) that includes a physical examination requirement elsewhere in statute or regulation.

- **Hawaii**
  "It shall be unlawful for any person . . . [to] prescribe . . . any controlled substance without a bona fide physician-patient relationship," and the definition of bona fide physician-patient relationship may be found in the definition section of the statute, including reference to a physical examination. [36]

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[32] MINN. STAT. § 151.37 (eff. date unclear).
[33] IOWA ADMIN. CODE r. 650-16.7(153) (eff. date unclear)."Emergency" here does not refer to a state of emergency declared by the government, but refers to circumstances wherein the prescriber is unable to provide a written prescription form immediately to the pharmacist so the pharmacist accepts an emergency oral prescription to avoid delay in providing necessary medications.
[34] D.C. MUN. REGS. tit. 22-B, § 1399 (eff. 2009).
[35] Twenty-three states. *See, e.g.*, ALASKA STAT. § 08.72.272 (eff. 2007); ALASKA ADMIN. CODE tit. 12, § 48.990 (eff. date unclear); ARIZ. ADMIN. CODE § R4-23-110 (eff. 2000); ARK. CODE ANN. 17-92-1004(c) (eff. 2007); CONN. GEN. STAT. ANN. § 20-613a (eff. 2005); DEL. CODE ANN. tit 16, § 4701 (eff. date unclear); FLA. STAT. ANN. § 465.023(1)(h) (eff. 2009); HAW. REV. STAT. § 329-1 (eff. 2008); HAW. REV. STAT. § 329-41 (eff. 2008); IDAHO ADMIN. CODE r. 23.01.01.315 (eff. 1999); KY. REV. STAT. ANN. § 218A.140; LA. ADMIN CODE. tit. 46, pt. XLV, § 7509 (eff. 2009); MO. REV. STAT. § 334.108 (eff. 2011); NEB. ADMIN. CODE § 172, Ch. 56, § 007 (eff. date unclear); NEV. ADMIN. CODE § 635.390 (eff. date unclear); N.H. REV. STAT. ANN. § 318-B:2 (eff. 2013); N.H. REV. STAT. § 318:52-a (eff. 2011); N.M. STAT. ANN. § 26-1-16(B) (eff. date unclear, 1987 or prior); N.M. CODE R. § 16.10.8 (eff. 2003); 21 N.C. ADMIN. CODE § 46.1801(b) (eff. 2003); N.D. CENT. CODE § 19-02.1-15.1 (eff. 2009); N.D. CENT. CODE § 19-03.1-22.4; OHIO ADMIN. CODE 4723-9-09 (eff. date unclear); OHIO ADMIN. CODE 4730-2-07 (eff. 2007); S.C. CODE ANN. § 40-47-113 (eff. 1976); S.C. CODE ANN. §§ 40-43-86; TENN. COMP. R. & REGS. 1050-02-.13 (eff. 2001); 22 TEX. ADMIN. CODE § 291.34 (eff. 2001); VT. ADMIN. CODE 20-4-1400:9.2 (eff. 2009); VA. CODE ANN. § 54.1-3434.1 (eff. 2008); 18 VA. ADMIN. CODE §§ 85-20-25.A, 85-50-176 (eff. 2005); 18 VA. ADMIN. CODE § 90-40-121 (eff. 2008); 18 VA. ADMIN. CODE §105-20-40 (eff. date unclear).
[36] HAW. REV. STAT. § 329-41; HAW. REV. STAT. § 329-1.

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- **Kentucky**
  Requires "a valid practitioner-patient relationship" in one provision[37] and defines that to include a "good faith prior examination" in another provision, which is then further defined to include a physical examination.[38]
- **South Carolina**
  Requires a "proper physician-patient relationship," which it defines within the same provision to include "at a minimum . . . personally perform[ing] and document[ing] an appropriate history and physical examination."[39]

Application with Reference to a Valid Prescription

Several states[40] have physical examination laws stating that a *prescription is not valid* unless it is based on a physical examination or a valid practitioner-patient relationship.

- **Vermont**
  A prescription or order for a "legend drug is not valid unless it is issued for a legitimate medical purpose . . . which includes a documented patient evaluation."[41]

Application Specific to Prescriber or Dispenser

Thirty-eight states[42] and the District of Columbia[43] have physical examination laws that apply specifically to prescribers.[44]

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[37] KY. REV. STAT. ANN. § 218A.140.
[38] *Id.* §§ 218A.010 (14), (34).
[39] S.C. CODE ANN. § 40-47-113.
[40] Seven states. *See, e.g.,* CONN. GEN. STAT. ANN. § 20-613a (eff. 2005); IDAHO CODE ANN. § 54-1733 (eff. 2006); LA. ADMIN. CODE tit. 46, pt. LIII, § 2515(A) (eff. date unclear, 1989 or 2004); MINN. STAT. ANN. § 151.37 (eff. 2008); MISS. CODE ANN. § 41-29-137; N.D. CENT. CODE § 19-03.1-22.4; VT. ADMIN. CODE 20-4-1400:9.2 (eff. 2009).
[41] VT. ADMIN. CODE 20-4-1400:9.2 (eff. 2009). "Legend drugs" refer to prescription-only drugs in the United States.
[42] *See, e.g.,* ALA. ADMIN. CODE r. 540-X-9-.11 (eff. 2000); ALASKA ADMIN. CODE tit. 12, § 40.967 (eff. date unclear); ALASKA STAT. § 08.72.272 (eff. 2007); ARIZ. ADMIN. CODE § R4-19-511(eff. 2005); 070.00.7 ARK. CODE R. § 07-00-0009 (eff. 2007); CAL. BUS. & PROF. CODE § 2242(a) (eff. 1981); CAL. BUS. & PROF. CODE § 2242.1(a) (eff. 2000); CAL. BUS. & PROF. CODE § 3110 (eff. 2005); CONN. AGENCIES REGS. § 21A-326-1 (eff. 1984); DEL. CODE ANN. tit. 16, § 4701 (eff. date unclear); FLA. STAT. § 456.44 (eff. 2011); GA COMP. R. & REGS. 360-3-.02 (eff. date unclear); HAW. REV. STAT. § 329-41(b) (eff. 2008); IDAHO ADMIN. CODE r.23.01.01.31 (eff. 1999); 844 IND. ADMIN. CODE 5-4-1 (eff. 2003); IOWA ADMIN. CODE r. 650-16.3(153) (eff. date unclear); 201 KY. ADMIN. REGS. 25:090 (eff. 2012); LA. ADMIN CODE. tit. 46, pt. XLV, § 6921 (eff. 1997); MD. CODE REGS.10.40.11.04 (eff. 2012); 234 MASS. CODE REGS. 9.05 (eff. date unclear); MINN. R. 6500.0600 (eff. 1988); MISS. ADMIN. CODE 30-17-2635:7.1 (eff. date 2012); MO. CODE REGS. ANN. tit. 19, § 30-1.068 (eff. 2000); MONT. ADMIN. R. 24.213.2301 (eff. 1998); NEB. ADMIN. CODE § 172, Ch. 56, § 007; NEV. ADMIN. CODE § 636.2882 (eff. date unclear); N.H. REV. STAT. ANN. §§ 318-B:1(XXVI-a) (eff. 2009); N.J. ADMIN. CODE § 13:35-7.2 (eff. date unclear); N.M. CODE R. § 16.10.16 (eff. date unclear); OHIO ADMIN. CODE 4730-2-07 (eff. 2007); OKLA. ADMIN. CODE § 510:5-9-2 (eff. date 1999); OR. ADMIN. R. 852-060-0025 (eff. date unclear); 49 PA. CODE § 16.92(b)(1) (eff. 1986); R.I. GEN. LAWS § 21-28-3.24 (eff. 1974); S.C. CODE ANN. § 40-47-965 (eff. date unclear); TENN. COMP. R. & REGS. 1000-04-.09 (eff. date unclear); 22 TEX. ADMIN. CODE § 190.8; UTAH ADMIN. CODE r.156-37 (eff. date unclear); VT. ADMIN. CODE 20-4-1400:9.2 (eff. 2009); VA. CODE ANN. § 54.1-3303(B) (eff. 2000); WASH. ADMIN. CODE § 246-817-915 (eff. 2011).
[43] D.C. MUN. REGS. tit. 17, § 4616 (eff. 2012).

- **Alabama**
  Requires that "the physician personally perform an appropriate history and physical examination" prior to prescribing.[45]
- **Alaska**
  Applies physical examination requirements to optometrists who prescribe controlled substances in addition to other prescribers.[46]

Twenty-seven states,[47] and the District of Columbia,[48] have physical examination laws that apply specifically to dispensers.

- **Delaware**
  Applies a requirement to internet pharmacies who act to dispense any prescription drug, including controlled substances, stating that the pharmacy may only dispense if "the practitioner issuing the prescription drug order to be filled or dispensed by the Internet pharmacy is a licensed practitioner" who has examined a Delaware patient." [49]

Frequently, as in the New Jersey regulation, the physical examination requirement applies directly to the practitioner either dispensing or prescribing.

- **New Jersey**
  "[A] practitioner shall not dispense drugs or issue prescriptions to an individual . . . without first having conducted an examination . . . ."[50]

A few states[51] and the District of Columbia[52] also require the dispenser to have knowledge that the patient and prescriber have a valid practitioner–patient relationship prior to dispensing a controlled substance.

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[44] Many of these thirty-eight states and the District of Columbia also have physical examination laws that apply to dispensers.
[45] ALA. ADMIN. CODE r. 540-X-9-.11 (eff. 2000).
[46] ALASKA STAT. § 08.72.272 (eff. 2007).
[47] *See, e.g.*, ALASKA ADMIN. CODE tit. 12, § 40.967 (eff. 2000); ARIZ. ADMIN. CODE § R4-19-511(eff. 2005); CAL. BUS. & PROF. CODE § 2242 (eff. 2000); CONN. AGENCIES REGS. § 21a-326-1 (eff. 1984); DEL. CODE ANN. tit. 16, § 4744(a)(1) (eff. 2008); HAW. REV. STAT. § 329-41 (eff 2008); HAW. REV. STAT. § 329-1 (eff. 2008); IDAHO ADMIN. CODE r. 23.01.01.315 (eff. 1999); 844 IND. ADMIN. CODE 5-3-2 (eff. 2003); IOWA ADMIN. CODE r. 650-16.3(153) (eff. date unclear); LA. REV. STAT. ANN. § 40:1238.4(eff. 2007); MINN. STAT. § 151.34 (eff. 1988); MISS. CODE ANN. § 41-29-137 (eff. date unclear); MONT. ADMIN .R. 24.213.2301(34) (eff. 1998); NEV. ADMIN. CODE § 639.945(1)(n) (eff. 2001); N.H. REV. STAT. § 318-B:2 (eff. 2013); N.J. ADMIN. CODE § 13:35-7.1A (eff. 2003); N.M. STAT. ANN. § 26-1-16 (eff. 1978); 21 N.C. ADMIN. CODE 46.1801 (eff. date 2003); N.D. CENT. CODE § 19-02.1-15.1 (eff. 2009); OHIO ADMIN. CODE 4731-11-09 (eff. 1999); 49 PA. CODE § 16.92(b)(1) (eff. 1986); S.C. CODE ANN. § 40-43-86 (eff. date unclear); TEX. OCC. CODE ANN. § 562.056 (eff. 2005).
[48] D.C. MUN. REGS. tit. 22-B, § 1300 (eff. 1986).
[49] DEL. CODE ANN. tit. 16, § 4744(a)(1).
[50] N.J. ADMIN. CODE § 13:35-7.1A.

- **Nevada**
  "Dispensing a drug as a dispensing practitioner to a patient with whom the dispensing practitioner does not have a bona fide therapeutic relationship" is unprofessional conduct.[53] In another provision, the law states that "a bona fide therapeutic relationship between the patient and practitioner shall be deemed to exist . . . [i]f the patient was physically examined by the practitioner within the [six] months immediately preceding the date the practitioner dispenses or prescribes a drug to the patient."[54]
- **Louisiana**
  Applies a knowledge standard to dispensing pharmacists, stating that "[a] pharmacist who *knows* that a prescription has been authorized in the absence of a valid physician-patient relationship . . . shall not fill such prescription."[55] Another provision defines that relationship to include "at least one medical evaluation with a person in the physical presence of the practitioner, without regard to whether portions of the evaluation are conducted by other practitioners."[56]

Electronic Questionnaires

Many states,[57] and the District of Columbia,[58] that require examinations before prescribing have also enacted provisions prohibiting practitioners from prescribing based solely on electronic patient questionnaires.

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[51] Five states. *See, e.g.,* DEL. CODE ANN. tit. 16, § 4744(a)(1); LA. REV. STAT. ANN. § 40:1238.4 (eff. 2007); NEV. ADMIN. CODE § 639.945(1)(n) (eff. 2001)); N.H. REV. STAT. ANN. § 318-B:2 (eff. date 2013); N.H. REV. STAT. ANN. § 329:1-c (eff. date 2009); 21 N.C. ADMIN. CODE 46.1801 (eff. date 2003).
[52] D.C. MUN. REGS. tit. 22-B, § 1300 (eff. 1986).
[53] NEV. ADMIN. CODE § 639.945(1)(n)
[54] *Id.* at § 639.945(3) (eff. 2001).
[55] LA. REV. STAT. ANN. § 40:1238.4(D) (emphasis added).
[56] *Id.* at § 40:1238.4(A)(2) (eff. 2007).
[57] Twenty-five states. *See, e.g.*, ALA. ADMIN. CODE r. 540-X-9-.11(3) (eff. 2000); ALASKA ADMIN. CODE tit. 12, § 40.967 (eff. date unclear); ARIZ. REV. STAT. ANN. §§ 32-1401 (eff. 2000); ARK. CODE ANN. § 17-92-1004 (eff. 2007); CAL.BUS. & PROF.CODE § 2242.1 (eff. 2000); CAL.BUS. & PROF.CODE § 4067 (eff. 2000); CONN. GEN. STAT. ANN. § 20-613a (eff. 2005); DEL. CODE ANN. tit. 16, § 4744(c)(1) (eff. 2008); FLA. ADMIN. CODE r. 64B8-9.014 (eff. 2003); FLA. ADMIN. CODE r. 64B15-14.008 (eff. date unclear); GA. COMP. R. & REGS. 360-3-.02 (eff. date unclear); IDAHO CODE ANN. § 54-1733(1) (eff. 2006); 844 IND. ADMIN. CODE 5-3-2 (eff. 2003); LA. REV. STAT. ANN. § 40:1238.4 (eff. 2007); LA. ADMIN CODE. tit. 46, pt. XLV, § 7505 (eff. 2009); LA. ADMIN CODE. tit. 46, pt. XLV, § 7509 (eff. 2009); LA. ADMIN CODE. tit. 46, pt. XLVII, § 4513 (eff. date unclear); MD. CODE REGS.10.32.05.05 (eff. 2009); 234 MASS. CODE REGS. 9.05 (eff. 1995); MISS. CODE ANN. § 41-29-137 (eff. 2009); 30-17 MISS. CODE R. § 2635:7.1 (eff. 2012); MO. REV. STAT. § 334.108 (eff. 2011); NEB. ADMIN. CODE § 172, Ch. 56, § 007 (eff. date unclear); NEB. ADMIN. CODE § 172, Ch. 90, § 008 (eff. date unclear); NEV. ADMIN. CODE § 453.3643 (eff. date unclear); NEV. ADMIN. CODE § 630A.144 (eff. 2003) ; N.H. REV. STAT. § 318-B:2 (eff. 2013); N.D. CENT. CODE § 19-02.1-15.1 (eff. 2009); N.D. CENT. CODE § 19-03.1-22.4; 22 (eff. 2009); S.C. CODE ANN. § 40-47-113 (eff. 2006); TENN. COMP. R. & REGS. 1000-04-.09 (eff. date unclear); TEX. ADMIN. CODE § 190.8(1)(L)(i)(II) (eff. date unclear, 2003–12); 22 TEX. ADMIN. CODE 22, § 291.29 (eff. 2001); VT. STAT. ANN. tit. 18, § 9361 (eff. 2012); VA. CODE ANN. § 54.1-3434.1 (eff. 2008).
[58] D.C. MUN. REGS. tit. 22-B, § 1300.7 (eff. 1986).

- **Louisiana**
  "A prescription issued solely upon the results of answers to an electronic questionnaire, in the absence of a documented patient evaluation including a physical examination, shall be considered issued outside the context of a valid physician-patient relationship and shall not be a valid prescription."[59]
- **Connecticut**
  Declares a prescription that is not based on a physical examination and "issued solely on the results of answers to an electronic questionnaire shall be considered to be issued outside the context of a valid practitioner-patient relationship and not be a valid prescription."[60]
- **Nebraska**
  Allows disciplinary action against a prescriber who issues "a prescription, via electronic or other means, unless the physician has obtained a history and physical evaluation of the patient."[61]
- **New Hampshire**
  Has a physical examination law that applies when controlled substances are delivered by mail and provides that "[i]t shall be unlawful for any pharmacy to ship finished prescription products . . . to patients . . . that w[ere] generated based upon the patient's submission of an electronic or online medical history form." [62] The law also states that "[s]uch electronic or online medical questionnaires, even if followed by telephonic communication between practitioner and patient, shall not be deemed to form the basis of a valid practitioner-patient relationship."[63] This law is similar to other laws prohibiting prescribing and dispensing based on electronic questionnaires but applies only to the *shipping* of the drugs.

Conclusion

This inventory compiles state physical examination requirements for prescribing and dispensing controlled substances. This inventory does not contain a full assessment of all relevant prescription drug laws. Practitioners should consult with legal counsel to become fully informed of the legal landscape concerning prescription drugs and how the laws are implemented and enforced in their state.

This document was written by researchers in the Public Health Law Program (PHLP), Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention (CDC),[64] with assistance from the Division of Unintentional Injury Prevention in CDC's National Center for Injury Prevention and Control.[65] For further technical assistance with this inventory or prescription drug laws, please contact

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[59] LA. REV. STAT. ANN. § 40:1238.4(B) (eff. 2007);
[60] CONN. GEN. STAT. ANN. § 20-613a (eff. 2005).
[61] NEB. ADMIN. CODE § 172, Ch. 90, § 008 (eff. date unclear).
[62] N.H. REV. STAT. ANN. § 318-B:2(XII-d) (eff. 2013).
[63] *Id.* "Practitioner-patient" relationship is defined to require an in-person exam. *See* N.H. REV. STAT. § 318-B:1(eff. 2011).
[64] Catherine Clodfelter, JD, MPH, Akshara Menon, JD, MPH, Carla Chen, JD, and Matthew Penn, JD, MLIS. We thank Rina Lieberman, JD, MPH, for her research assistance.
[65] Noah Aleshire, JD, and Leonard Paulozzi, MD, MPH.

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PHLP.[66] For technical assistance on all other opioid pain reliever-related topics, please contact CDC's Division of Unintentional Injury Prevention.[67]

PHLP provides technical assistance and public health law resources to advance the use of law as a public health tool. PHLP cannot provide legal advice on any issue and cannot represent any individual or entity in any matter. PHLP recommends seeking the advice of an attorney or other qualified professional with questions regarding the application of law to a specific circumstance. The findings and conclusions in this summary are those of the author and do not necessarily represent the official views of CDC.

This menu includes laws enacted through December 4, 2013.

Published January 29, 2015.

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[67] Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Hwy. NE, MS F-62, Atlanta, GA 30341. Email: lbp4@cdc.gov. Web: http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/laws/index.html.

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Joint Statement on Antibiotic Resistance from 25 National Health Organizations and the Centers for Disease Control and Prevention

Alliance for the Prudent Use of Antibiotics

American Academy of Pediatrics

American Academy of Physician Assistants

American Academy of Urgent Care Medicine

American Medical Directors Association

American Public Health Association

American Society of Health System Pharmacists

Association for Professionals in Infection Control and Epidemiology, Inc.

Association of State and Territorial Health Officials

Center for Disease Dynamics, Economics & Policy

Centers for Disease Control and Prevention

Consumers Union

Council of State and Territorial Epidemiologists

Infectious Diseases Society of America

Institute for Healthcare Improvement

Since their introduction into medicine in 1941, antibiotics have saved millions of lives and transformed modern medicine. As a result, bacterial infections have become easily treatable, and the horizons for surgeries, transplants, and more complicated life-saving procedures have expanded. But increasing antibiotic resistance is leading to higher treatment costs, longer hospital stays, and unnecessary deaths.

The more we use antibiotics, the more we contribute to the pool of antibiotic-resistant microbes. The development of resistance is an inevitable byproduct of exposure to antibiotics. All antibiotic use, whether warranted or not, places selection pressure on bacteria, and some organisms that possess genetic mutations will survive antibiotic treatment. Over time, resistance threatens to return us to an era where simple bacterial infections will once again be deadly.

As representatives from a range of fields concerned with human health, we jointly recognize our collective responsibility to protect the effectiveness of all antibiotics – those we have today, and those yet to be developed. We also recognize the potential for these life-saving drugs to be overused in both the human and agricultural sectors. Antibiotics are a shared resource, and every individual should consider how each prescription or use of antibiotics affects the overall effectiveness of the antibiotic arsenal. The problem is defined by challenges on both the demand and supply sides of the equation – just as antibiotics are frequently overused, there are few new drugs in the development pipeline.

Understanding this situation, we jointly commit to the following principles to both conserve and replenish our antibiotic resources:

- To seek greater coordination among all stakeholders in antibiotic effectiveness, including healthcare personnel, hospital administrators, policymakers, patients, and individuals working in medical centers, universities, and pharmaceutical companies to promote knowledge sharing and a mutual commitment to improving antibiotic use, a practice referred to as antibiotic stewardship
- To work towards optimizing antibiotic use through antibiotic stewardship programs and interventions, which help ensure that patients get the right antibiotics at the right time for the right duration

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National Association of County and City Health Officials

National Association of Directors of Nursing Administration in Long Term Care

National Association of Public Hospitals

Pediatric Infectious Disease Society

Public Health Foundation

Robert Wood Johnson Foundation

Society of Hospital Medicine

The Pew Charitable Trusts

The Society for Healthcare Epidemiology of America

The Society of Infectious Diseases Pharmacists

Trust for America's Health

- To identify the most effective examples of antimicrobial stewardship and to replicate these strategies and best practices, while also taking into account local context
- To support research that deepens our understanding of the current situation and trends in antibiotic resistance and use
- To use information about the drivers of antibiotic use to contribute to the evolving definition of "appropriate antibiotic use," and to use this definition to guide stewardship efforts, including the education of the general public and healthcare personnel at all levels
- To improve surveillance for drug-resistant infections and to encourage reporting activities in a way that supports both positive outcomes and accuracy
- To encourage the development of pharmaceutical products to combat antibiotic resistance, including new antibiotics or novel therapies, compounds to boost antibiotic effectiveness, diagnostics to better diagnose infections and their resistance characteristics, and vaccines to prevent infections from occurring
- To recognize that antibiotic resistance is one of the world's most pressing public health threats and that global collective action is required to effectively address the challenge of managing our scarce supply of effective antibiotics
- To acknowledge that the way we use antibiotics today in patients impacts how effective they will be in the future in other patients
- To communicate that antibiotic resistance is an infectious disease and public health concern: some resistant bacteria have the potential to spread rapidly from person to person, which increases the threat of resistant infections
- To work with regulatory, veterinary and industry partners to promote the judicious use of antibiotics in food animals
- To reinforce the judicious use of antibiotics in agriculture by: limiting the use of medically important human antibiotics in food animals; supporting the use of such antibiotics in animals only for those uses that are considered necessary for assuring animal health; and having veterinary oversight for such antibiotics used in animals

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

CDC Encourages Safe Antibiotic Prescribing and Use

Be Antibiotics Aware: protect patients now and fight antibiotic resistance

Press Release

For Immediate Release: Wednesday, November 15, 2017

Contact: Media Relations (https://www.cdc.gov/media)
(404) 639-3286

November 13, 2017, kicked off U.S. Antibiotic Awareness Week and World Antibiotic Awareness Week. The Centers for Disease Control and Prevention (CDC) recognizes this week with an updated educational effort, *Be Antibiotics Aware: Smart Use, Best Care* (https://www.cdc.gov/antibiotic-use/week/index.html), to support the nation's efforts to combat antibiotic resistance through improved use of these life-saving medications.

Each year, at least 2 million Americans become infected with antibiotic-resistant bacteria, and at least 23,000 people die as a result. As part of U.S. Antibiotic Awareness Week, the Department of Health and Human Services (HHS), on behalf of the Interagency Combating Antibiotic Resistant Bacteria (CARB) Task Force, has released a Progress Report (https://aspe.hhs.gov/pdf-report/national-action-plan-combating-antibiotic-resistant-bacteria-progress-report-years-1-and-2) to detail the significant progress during the first two years of implementation of the National Action Plan for Combatting Antibiotic-Resistant Bacteria (https://www.cdc.gov/drugresistance/pdf/national_action_plan_for_combating_antibotic-resistant_bacteria.pdf).

"Antibiotic resistance is a critical public health concern, and this educational effort is an excellent opportunity to drive change in improving antibiotic use, give doctors the tools they need to improve antibiotic prescribing, and help patients better protect their health," said CDC Director Brenda Fitzgerald, M.D.

Prescribing the right antibiotic at the right time, in the right dose, and for the right duration helps fight antibiotic resistance, protects patients from unnecessary side effects, and helps ensure these life-saving medicines will be available for future generations.

Though the United States has made progress toward optimal prescribing and use of antibiotics for patients, there is still room for improvement. The *Be Antibiotics Aware* effort helps inform healthcare professionals and patients about proper antibiotic use and encourages open discussion among doctors and patients.

Antibiotics are critical tools for treating a number of common infections, such as pneumonia, and for life-threatening conditions including sepsis. However, when patients take antibiotics unnecessarily, they are at risk for side effects and get no benefit from the drugs. Minor side effects can include rash, dizziness, nausea, diarrhea, and yeast infections. Major side effects can include allergic reactions and *Clostridium difficile* (*C. difficile* or C. diff) infection, which can cause severe diarrhea and colon damage and can cause death.

"Despite prescribing guidelines, some healthcare professionals report giving antibiotics when they aren't needed because of fear of misdiagnosis or pressure from patients," said Lauri Hicks, D.O., director, Office of Antibiotic Stewardship, Division of Healthcare Quality Promotion, CDC. "CDC encourages healthcare professionals and patients to talk through the best ways to feel better and what treatment options are most effective."

The *Be Antibiotics Aware* educational effort also aligns with antibiotic stewardship activities mentioned in the National Action Plan for Combating Antibiotic Resistant Bacteria (CARB), (https://obamawhitehouse.archives.gov/sites/default/files/docs/national_action_plan_for_combating_antibotic-resistant_bacteria.pdf) supports the National Action Plan to Prevent Health Care-Associated Infections (HAIs): Road Map to Elimination (https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/national-action-plan-prevent-health-care-associated) , and complements other patient safety initiatives, such as the *Get Ahead of Sepsis* education effort launched in August 2017.

There are many ways to get involved in U.S. Antibiotic Awareness Week 2017. Visit www.cdc.gov/antibiotic-use (http://www.cdc.gov/antibiotic-use) to learn more about how to participate.

CDC is a global leader in efforts to improve antibiotic prescribing and use practices. Read more about Antibiotic Use in the United States, including progress and opportunities (https://www.cdc.gov/antibiotic-use/stewardship-report/index.html). These efforts are supported by CDC's Antibiotic Resistance Solutions Initiative (https://www.cdc.gov/drugresistance/solutions-initiative/index.html). To learn more about antibiotic resistance, visit www.cdc.gov/drugresistance (http://www.cdc.gov/drugresistance).

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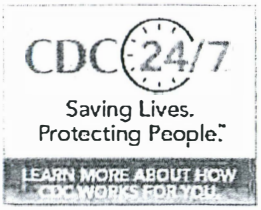

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How do I view different file formats (PDF, DOC, PPT, MPEG) on this site? (https://www.cdc.gov/Other/plugins/)

(https://www.cdc.gov/Other/plugins/#pdf)

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ATTACHMENT 4

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Testimony of Dr. Brenda Miller
Member of the North Dakota Board of Medicine

Chairman Devlin, and the Administrative Rules Committee my name is Brenda Miller, I am a licensed physician in the state of North Dakota and a member of the North Dakota Board of Medicine.

I appear before you today to address the comments we received in response to our telemedicine rule regarding the development of the patient-licensee relationship and more specifically the interactive video requirement. I realize that this portion of our rule has some opposition. I hope I can help you all understand why the board believes this portion of our rule is very important.

In the beginning conversations of this rule, our Board was insistent that there needed to be a visual examination either in person, through video or using another properly licensed individual. Our board believes that when establishing a new patient licensee relationship, the physician needs to be able to see the patient.

Visual observation is especially important during a psychological exam. The provider will want to see if the patient exhibits restlessness, darting eyes, mouth movements, trunk movements as these are all signs of potential problems that need to be addressed properly.

Visual observation is equally important in pediatric care. The pediatrician will want to see if the patient is irritable or smiling, if the patient is consolable, if the patient is flushed or has a rash, if the patient appears hydrated, when they cry do they have tears etc.

Visual observation of elderly patients provides the physician with valuable information as well. It is important to see if the patient is able to ambulate on their own. Are they able to answer questions without assistance from a loved one?

When considering prenatal care visual observation is also extremely valuable. It would not be within the standard of care to make any decisions without being able to listen to the fetal heart tones.

The requirements established within this rule by our board help ensure that the standard of care is being met. In traditional medicine physicians have been able to provide follow up care through a phone call. There has always been an acceptance of the ability to see a patient in the office and then receive a phone call from them to discuss the care if something needed to be addressed. However, it would have never been acceptable or within the standard of care to receive a cold call from an unknown patient who was referred to you and to diagnose and treat them based on a phone call or an email. This is what we are attempting to avoid. With the introduction of what we now call telemedicine we have an obligation to provide parameters that everyone understands to define a new encounter between a patient and a doctor who is unknown to them.

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To allow diagnosis and treatment to occur between a patient and a new doctor based on only a telephone call and a questionnaire leaves the public exposed to misdiagnosis due to a lack of proper evaluation. It also may contribute to the over prescription of antibiotics which is currently one of the CDC's major concerns.

The ultimate goal is patient safety by assuring the standard of care is not altered by the type of visit.

Chairman Devlin called on Mr. Dustin Peyer for comments. Mr. Peyer said because of his grandmother's medical issues, he has been personally affected by the need for medical marijuana. He said the medical marijuana program may want to consider the impact of the legalization of recreational marijuana on the medical marijuana program.

Chairman Devlin said the State Department of Health only has the authority to deal with laws that have passed.

Chairman Devlin called on Mr. Paul Aughinbaugh, Fargo, for comments. Mr. Aughinbaugh said he is a potential dispensary applicant. He said if recreational marijuana is legalized, he is concerned about what would happen to a dispensary that has paid over $90,000 for certification.

Mr. Wahl said the department's only duty is to implement the medical marijuana program. He said the program is being implemented based upon the law passed by the Legislative Assembly in 2017. He said the department will implement the medical marijuana program as timely as possible. Regarding dispensaries located in cities, he said to ensure access to as many people as possible with as little travel as possible, an eight-region map has been created. He said the map is on the department's website. He said one dispensary in each of those eight regions is expected. He said dispensaries are permitted to offer home delivery.

In response to a question from Senator Heckaman, Mr. Wahl said local zoning officials will be provided a form to sign to confirm the dispensary facility complies with local zoning requirements.

In response to a question from Senator Klein, Mr. Wahl said the dispensary fee is set in state law. He said the law does not include a provision for a refund if the recreational marijuana measure passes.

In response to a question from Senator Heckaman, Mr. Wahl said the program's registration and application fees will be deposited in the Bank of North Dakota in the same way as any other state program.

NORTH DAKOTA BOARD OF MEDICINE

Chairman Devlin called on Ms. Bonnie Storbakken, Executive Director, North Dakota Board of Medicine, for testimony (Appendix E) regarding rules relating to telemedicine carried over from the December 5, 2017, meeting.

In response to a question from Chairman Devlin, Ms. Storbakken said Teladoc was not invited to sit down with the board to discuss the face-to-face consultation requirement.

Chairman Devlin called on Dr. Brenda Miller, North Dakota Board of Medicine, for testimony (Appendix F) regarding the telemedicine rule.

In response to a question from Representative Pyle, Dr. Miller said a physician should not give advice without establishing a relationship.

Chairman Devlin called on Mr. John Ward for testimony (Appendix G) regarding the telemedicine rules. Mr. Ward said he represents Teladoc. He said interactive audio is used in every state. He said the physician has the ability to request high-resolution photos. He said interactive audio is an acceptable telemedicine tool used across the country. He said the North Dakota Board of Medicine conducted open meetings regarding the carried over telemedicine rules but did not give the public an opportunity to speak. He said telemedicine consultations are done by physicians who are licensed by the board. He said Teladoc has not experienced malpractice claims as a result of its practices. He said Arkansas is the only other state with a face-to-face consultation requirement. He said the Minnesota standard of care for telemedicine is the same as for inpatient care.

In response to a question from Representative Koppelman, Mr. Ward said if a physician who uses interactive audio is unable to diagnose a patient using that method, the physician is expected to advise the patient to make an appointment for an in-person visit with the patient's health care provider.

Chairman Devlin called on Mr. Jack McDonald for testimony regarding the telemedicine rule. Mr. McDonald distributed a letter (Appendix H) from America's Health Insurance Plans (AHIP) regarding concerns about the changes being proposed by the North Dakota Board of Medicine. He said AHIP believes the rules fail to consider the evolving nature of telemedicine technology and limit a patient's options when deciding on the best course of action to obtain health care.

Representative Koppelman said he understands the board's obligation to protect the public. He said telemedicine is defined in North Dakota Century Code (NDCC). He said the board has indicated it will not change its position on the face-to-face requirement. He said it is important to stay current with technology. He said the

board followed the committee's directive regarding the prescribing of opioids for medication-assisted treatment situations.

It was moved by Representative Koppelman, seconded by Senator Kilzer, and carried on a roll call vote to:

1. **Adopt the changes to the opioid restriction as proposed by the North Dakota Board of Medicine;**
2. **Retain the definitions contained in North Dakota Administrative Code (NDAC) Section 50-02-15-01 on page 215 of Supplement 368; and**
3. **Void NDAC Sections 50-02-15-02 and 50-02-15-03 on the finding that, under NDCC Section 28-32-18 (1) (c)(d)(e), the rules failed to comply with express legislative intent; are in conflict with state law; and are arbitrary and capricious.**

Representatives Devlin, Boehning, Boschee, Koppelman, Louser, Pyle, Schneider, Seibel, Toman, and Weisz and Senators Anderson, Armstrong, Heckaman, Kilzer, Klein, Meyer, Poolman, and Rust voted "aye." No negative votes were cast.

Representative Koppelman said the North Dakota Board of Medicine should start over on the telemedicine rules.

Senator Kilzer said telemedicine is needed now more than ever. He said the hands-on medicine is being done more and more by nonphysicians such as physician's assistants and nurse practitioners. He said the requirements for telemedicine are a policy decision for the Legislative Assembly. He said third-party coverage is an issue insurance companies continue to face without resolution. He said another issue is the crossing of state boundaries when providing medical consultations. He said a study of telemedicine is needed.

BOARD OF EXAMINERS ON AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

Chairman Devlin called on Ms. Kelli Ellenbaum, Chairperson, Board of Examiners on Audiology and Speech-Language Pathology, for testimony (Appendix I) regarding April 2018 rules adopted by the board.

Senator Poolman said she appreciated the efforts of the board to increase the number of licensees in the workforce.

In response to a question from Representative Pyle, Ms. Ellenbaum said the University of North Dakota has space for 22 students in its program. She said many of the licensees practicing in the state have degrees from Minot State University and Minnesota State University - Moorhead. She said the University of Mary is in the process of establishing a graduate program in audiology and speech-language pathology.

In response to a question from Representative Schneider, Ms. Ellenbaum said the board is prepared for the extra workload that will result from the increasing number of graduates in the state. She said there are 400 to 600 open positions in the state. She said the shortage creates heavy caseloads for licensees.

In response to a question from Representative Weisz, Ms. Ellenbaum said Blue Cross Blue Shield covers the services of speech-language pathology assistants but most third-party payers require a licensed speech-language pathologist to sign off if the work is done by licensed assistants.

In response to a question from Senator Kilzer, Ms. Ellenbaum said fully trained speech-language pathologists and assistants are in high demand.

In response to a question from Representative Boehning, Ms. Ellenbaum said increasing the number of program slots at the colleges in the state is not enough to meet the demand. She said the colleges that offer the degree are experiencing a shortage of professors to teach the required courses.

Senator Anderson said it is difficult to get the North Dakota University System to increase faculty without increased funding.

INDUSTRIAL COMMISSION

Chairman Devlin called on Mr. Bruce Hicks, Assistant Director, Oil and Gas Division, Industrial Commission, for testimony (Appendix J) regarding April 2018 rules adopted by the Industrial Commission.

In response to a question from Senator Rust, Mr. Hicks said the delayed effective date of July 1, 2019, for the rules will give the industry time to make necessary software updates. He said the date also gives the Legislative Assembly the opportunity to make changes during the 2019 legislative session, if necessary.

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Chairman Weisz and members of the House Human Services Committee my name is Brenda Miller I am licensed physician in the state of North Dakota and a member of the North Dakota Board of Medicine.

I appear before you today to provide give my support for Engrossed Senate Bill 2094 with the amendment the following amendment. We recommend the following language be truck from the Bill Page three line 19, "or store-and-forward technology". I would like to provide some context behind the Board's desire for this amendment and the development of the patient-licensee relationship. I realize that this portion of our bill has some opposition. I hope I can help you all understand why the board believes this language is important.

When the Board initially began drafting this as a rule, our Board was insistent that there needed to be a visual examination either in person, through video or using another properly licensed individual. Our board believes that **when establishing a new** patient- licensee relationship, the physician or another provider working with the physician needs to be able to see the patient. I would like to make it clear that this section applies to the establishment of a new patient-licensee relationship via telemedicine and not to the use of telemedicine with an already established patient. There are many reasons our Board believes that having visual observation is necessary in the instance of treating a new patient.

Visual observation is an important factor when verifying the patient's identity and age. The patient also has the ability to confirm they are in fact being treated by licensed providers. Without this, there is potential for the physician to be treating a patient that is not the age they represent or who they represent. There is also potential for the patient to be giving their medical information to someone who is not a licensed or qualified provider. Our Board has received complaints of this nature. In one instance, a patient was unsure of the identity of the person representing themselves as a physician on the other end of the phone line and email. Another complaint involved patients receiving cold calls asking them about pain medication and then receiving pain medication in the mail. Unfortunately, these things happen and it is the purpose of this Board to protect the public from these situations. The Board believes with this bill it can best protect the public from situations like these.

Visual observation is especially important during a psychological exam. The provider will want to see if the patient exhibits restlessness, darting eyes, mouth movements, and trunk movements as these are all signs of potential problems that need to be addressed properly.

Visual observation is equally important in pediatric care. The pediatrician will want to see if the patient is irritable or smiling or if the patient is consolable etc. It is also important to see if the patient is flushed or has a rash. A provider will also need to see if the patient appears hydrated, and when they cry, do they have tears?

Visual observation of elderly patients provides the physician with valuable information as well. It is important to see if the patient is able to ambulate on their own. Are they able to answer questions without assistance from a loved one?

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When considering prenatal care visual observation is also extremely valuable. It would not be within the standard of care to make any decisions without being able to listen to the fetal heart tones.

The requirements established within this rule by our board help ensure that the standard of care is being met. In traditional medicine, physicians have been able to provide follow up care through a phone call. This has always been acceptable and still would be acceptable because the provider had already seen the patient in the office and then receive a phone call from them to discuss their care if something needed to be addressed. However, it has never been acceptable or within the standard of care to receive a cold call from an unknown patient who was referred to you and to diagnose and treat them based on a phone call or an email. This is exactly what we are attempting to avoid with this bill language.

With the introduction of what we now call telemedicine, we have an obligation to provide parameters that everyone understands to define a **new encounter** between a patient and a doctor who is unknown to them. To allow diagnosis and treatment to occur between a new patient and a new doctor based only on a telephone call and a questionnaire, leaves the public exposed to misdiagnosis due to a lack of proper evaluation. It also may contribute to the over prescription of antibiotics which is currently one of the CDC's major concerns.

The Board's ultimate goal is to ensure the standard of care is not altered based on the type of visit one would have.

I want to thank you for the opportunity to speak on behalf of the Board of Medicine and I am happy to answer any questions you may have.

Brenda Miller, MD
Board Member of the North Dakota Board of Medicine

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Testimony
Engrossed Senate Bill 2094 – Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman

March 25, 2019

Chairman Weisz and members of the House Human Services Committee, I am Dr. Laura Kroetsch. I am a board-certified psychiatrist licensed in the state of North Dakota. I work as the field services medical director for the North Dakota Department of Human Services. I am here today to provide testimony regarding Engrossed Senate Bill No. 2094. I support this bill but am here to recommend some changes to the language to ensure that medical examinations continue to occur via telehealth/telemedicine in a safe and equivalent manner as an in-person examination. All references to line numbers in the bill are referring to those provided in the First Engrossment of the bill.

I appreciate and agree with the proposed language within the bill on page 3, lines 1 and 2, that reads "A licensee is held to the same standard of care and same ethical standards, whether practicing traditional in-person medicine or telemedicine." However, page 3 lines 3 and 4 reads "The following apply in the context of telemedicine:" and lines 15 through 26, specifically subsection (3)(a), shows that the proposed language has changed from "A video examination" to "An examination utilizing secure videoconferencing or store-and-forward technology for appropriate diagnostic testing and use of peripherals that would be deemed necessary in a like in-person examination or evaluation meets this standard, …"

This change in language could be interpreted to allow for the medical "examination" to occur using either secure videoconferencing or store-and-forward technology. An examination must utilize "secure videoconferencing" to meet the standard expectations of an "examination". An initial "examination" in medicine is our most thorough encounter with a patient where the clinician engages with the patient,

listens to what brings them in, uses medical knowledge to ask specific clarifying questions, narrows down the plausible medical conditions, and subsequently determines what medical tests, procedures, referrals, and follow up may be warranted. For office-based visits it is often one of the most expensive non-procedural billing codes submitted for patient encounters. This "examination" establishes the licensee-patient relationship and is the foundation on which on-going care is provided. An incomplete examination can lead to incorrect or delayed diagnosis, unnecessary testing, and poor outcomes.

To allow store-and-forward technology to meet the state legal definition of "examination" would not be consistent with the first line quoted regarding standard of care and professional ethics, page 3 lines 1 and 2, which reads "A licensee is held to the same standard of care and same ethical standards, whether practicing traditional in-person medicine or telemedicine". If the licensee is only able to view/hear what is submitted to them electronically via stored/saved video transmission and does not have the ability to have meaningful concurrent discussion, the licensee is not "examining" the patient, the licensee is assimilating information they are provided and is providing recommendations. Without the ability to ask real-time questions, clarify comments, respond to non-verbal cues the encounter is not equivalent to an in-person exam. To include the text "store-and-forward" in this section encourages unnecessary ambiguity, which could be avoided by returning to the previous language and simply stating "A video examination utilizing…" There is no downside to the added verbiage of utilizing "secure videoconferencing" as this is an essential component to all electronic transmission of medical HIPAA regulated information.

In summary, an "examination" requires an interaction between a licensee and a patient.

The larger telemedicine umbrella covers services that do not require a licensee and patient to establish this type of relationship. Those types of medical interpretations (not examinations) are already covered in the language on page 3, lines 27 through 31 and on page 4, lines 1 through 3. This subsection provides in part that: "In

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certain types of telemedicine utilizing asynchronous store-and-forward technology or electronic monitoring, such as teleradiology or intensive care unit monitoring, it is not medically necessary for an independent examination of the patient to be performed".

I also support and appreciate the intent of Section 4 of the bill, found on page 4, lines 10 through 23.

Thank you for your time. I would be happy to answer any questions you have.

Laura Kroetsch, MD

Department of Human Services Field Services Medical Director

2624 9th Avenue South

Fargo, ND 58103

Phone: 701-298-4412

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PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2094

Page 3, line 19, replace "An" with "A video"

Page 3, line 19, remove "or store-and-forward"

Page 3, line 20, remove "technology"

Renumber accordingly

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Lyle W. Kirmis
Patrick J. Ward
Lawrence E. King, P.C.**^^
Constance N. Hofland**
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(1944-2001)

March 25, 2019

RE: SB 2094

Dear Chairman Weisz and members of the North Dakota House Human Services Committee:

Good Afternoon, my name is John Ward and I am an attorney and lobbyist from Bismarck, North Dakota. I am before you today representing Teladoc Health. I have the pleasure of introducing Claudia Tucker, who is the Vice President of Government Affairs for Teladoc Health and has many years of experience in the field of health care legislation.

Teladoc Health supports SB 2094.

The legislation that is before you has a history as a proposed administrative rule by the North Dakota Board of Medicine. I know a couple of the members of this Committee also sit on the Administrative Rules Committee and were present at multiple hearings where testimony was given regarding the proposed Administrative Rule. The Administrative Rules Committee rejected the proposed language that restricted the establishment of the physician-patient relationship to video only. The Administrative Rules Committee amended the proposed administrative rule to include a definition of telemedicine and a section allowing for the prescription of controlled substance in the treatment of opioid use disorder. The administrative rule is codified at N.D.A.C. Chapter 15-02-15.

During the Administrative Rules Committee hearings, Doctor and former Senator Kilzer spoke to the rural health crisis that exists throughout our state. The Administrative Rules Committee unanimously rejected the North Dakota Board of Medicine's language that restricted both physician's discretion and provided an arbitrary restriction on the use of all forms of available technology in establishing the physician-patient relationship.

More than forty states have telemedicine language in either their statutes or administrative codes. About five states have no language regarding the practice of telemedicine in their statutes or administrative code. The vast majority of states have what is referred to as "technology-neutral" language as regards telemedicine. Technology-neutral means that the language is not specific or restrictive of the use of various forms of technology available to the physician. All North Dakota licensed physicians that practice medicine in north Dakota are held to a standard of care. These licensed physicians, whether they are practicing telemedicine or traditional medicine, are responsible for the care and treatment that they provide to North Dakota patients.

The role of the North Dakota Board of Medicine and administrative agencies generally are to set standards for the testing of applicants who will be granted a license from whatever Board he or she is seeking licensure. The role of the Board is not to invade a physician's discretion in utilizing technology as the physician deems appropriate based on his or her training and experience.

I applaud the legislature in introducing and implementing legislation this session, which operates to clarify the scope of an administrative agency's authority and protects the citizens of North Dakota from unchecked administrative agency regulation. This preserves the separation of powers and the checks and balances that are essential to the effective administration of our state government.

So, this brings us to SB 2094. SB 2094 was introduced by the North Dakota Board of Medicine in largely the same form as was rejected by the North Dakota Administrative Rules Committee only a year earlier. The Senate Human Services Committee, similar to the Administrative Rules Committee, adopted an amendment that took SB 2094 from its restrictive, technology-specific language to a technology neutral version of SB 2094. This is now the bill which is before this Committee. The Senate amendment was taken from language provided to Senator Howard Anderson from the Federation of State Medical Boards that includes the use of "store-and-forward" technology as an appropriate method for establishing the physician-patient relationship. There were multiple hearings on SB 2094 in the Senate and the Senate Human Services Committee spent multiple days in discussion during committee work before unanimously voting to adopt the amendment to technology neutral language. The whole of the Senate body adopted the amended SB 2094 unanimously.

We urge a DO PASS on SB 2094 and the rejection of any potential amendment to remove "store-and-forward technology".

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I appreciate the opportunity to provide you with some background regarding SB 2094 and I would be happy to answer any questions.

I will now turn it over to Claudia Tucker, who can provide you with more substantive information regarding the importance of technology neutral language in the ever evolving area of telemedicine technology.

Thank you.

Respectfully,

John E. Ward

Minnesota

PRACTICE OF TELEMEDICINE.

Subd. 1.Definition. For the purposes of this section, "telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way interactive audio, and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

Subd. 2. Physician-patient relationship. A physician-patient relationship may be established through telemedicine.

Subd. 3. Standards of practice and conduct. A physician providing health care services by telemedicine in this state shall be held to the same standards of practice and conduct as provided in this chapter for in-person health care services.

[MN Statute §147.033]

Montana

Telemedicine means the practice of medicine using interactive electronic communication, information technology, or other means between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine typically involves the application of secure videoconferencing or store-and-forward technology, as defined in 33-22-138. The term does not mean an audio-only telephone conversation, an e-mail or instant messaging conversation, or a message sent by facsimile transmission.

[MT Code §37-3-102]

"Telemedicine" means the use of interactive audio, video, or other telecommunications technology that is:

(A) used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located; and

(B) delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq.

(ii) The term includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.

(iii) The term does not include the use of audio-only telephone, e-mail, or facsimile transmissions.

[MT Code §33-22-138]

(1) Treatment of a patient who is physically located in Montana by a licensee using telemedicine occurs where the patient is physically located.

(2) The licensee using telemedicine in the treatment and care of patients in Montana shall adhere to the same standards of care required for in-person medical care settings.

(3) A physician-patient relationship may be established for purposes of telemedicine:

(a) by an in-person medical interview and physical examination when the standard of care requires an in-person encounter;

(b) by consultation with another licensee or health care provider who has a documented relationship with the patient and who agrees to participate in, or supervise, the patient's care; or

(c) through telemedicine if the standard of care does not require an in-person encounter.

(4) The licensee using telemedicine in patient care may prescribe Schedule II drugs to a patient only after first establishing a physician-patient relationship through an in-person encounter which includes a medical interview and physician examination.

(5) The licensee using telemedicine in patient care shall:

(a) make available to the patient verification of the licensee's identity and credentials;

(b) verify the identity of the patient;

(c) establish a physician-patient relationship prior to initiating care;

(d) obtain a medical history sufficient for diagnosis and treatment in keeping with the applicable standard of care prior to providing treatment, issuing prescriptions, or delegating the patient's medical services to other health care providers;

(e) delegate the patient's medical care only to health care providers:

(i) who are known by the licensee to be qualified and competent to perform the delegated services;

(ii) with whom the patient has an established provider-patient relationship; or

(iii) who have physical or electronic access to the licensee for consultation and follow-up while the patient is under the licensee's or the delegee's care;

(f) securely maintain and make timely available:

(i) to the patient or the patient's representative all relevant medical and billing records received or produced in connection with the patient's care; and

(ii) to other health care providers all medical records received or produced in connection with the patient's care.

[MT Board of Medical Examiners, Rule II, Practice Requirements for Physicians Using Telemedicine (2018)]

South Dakota

No statute or regulations

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Teladoc HEALTH

TESTIMONY BY TELADOC HEALTH TO THE HUMAN SERVICES COMMITTEE IN SUPPORT OF SB2094

Claudia Duck Tucker, VP of Government Affairs for Teladoc Health

Good afternoon Chairman Weisz and members of the Committee:

My name is Claudia Tucker and I am the Vice President of Government Affairs for Teladoc Health. In this capacity I have oversight of all state legislative and regulatory affairs as well as for all work at the federal level. I have a unique view of what is going on nationally relative to telemedicine policy and how the states are addressing it.

Teladoc is the world's largest telemedicine company delivering on-demand healthcare anytime via mobile devices, a web-based portal, video and interactive audio. We connect our members with a staff of over three hundred doctors and a network of over 3100 board certified physicians with an average of over 15 years of experience. In 2018 Teladoc Health completed over 2.5 million virtual visits and we have over 24 million members worldwide. Telemedicine is dynamic and evolving and we appreciate the role that the Legislature and Board of Medicine have in considering an approach that is protective of public health and maintaining high quality care for patients while being permissive of innovation that allows for expanded telemedicine services in the state. With over 100 proprietary clinical guidelines, NCQA and HITRUST certification, nothing is more important to Teladoc Health than quality health care.

Teladoc supports SB 2094 in its current form as amended by the Senate. The language of the amendment introduced by Senator Howard Anderson came from the Federation of State Medical Boards' model policy. The Senate Amendment removed the restrictive, technology-specific language. The Amendment that was adopted by the Senate Human Services Committee included store-and-forward technology along with secure videoconferencing as a means to establish the physician-patient relationship. The amended bill passed the North Dakota Senate unanimously. SB 2094 with the inclusion of the store-and-forward language will allow ALL citizens of North Dakota to enjoy the benefits of telemedicine and not just those who are computer savvy or have the financial means to buy a computer or smart phone.

If the store-and-forward language were removed, North Dakota join only two other states with this initial video only requirement. The other two states are Arkansas and Delaware. Minnesota, Montana and South Dakota all allow either video or audio using asynchronous store and forward technology in establishing the physician-patient relationship. Store-and-forward technology references

additional information that is available to the physician, such as electronic information, imaging, or other information that is available to the physician. This can include the patient's medical history or chart.

I want to acknowledge that interactive audio will not be appropriate in every situation. However, if the standard of care requires the physician actually see the patient during the telemedicine consult, the physician has the ability and the responsibility to tell the patient that the visit must have a video component. Let me be clear; while I am here on behalf of Teladoc, this is not a "Teladoc" concern, this is an industry concern. Teladoc does both video and interactive audio, so for us it really is patient choice and physician discretion. I am here today because our clients and their employees have asked that we do everything possible to protect this important benefit that allows access to quality care. There is no good reason why the citizens of North Dakota should be disenfranchised from quality healthcare just because they don't have broadband or a smart phone or a computer. It would be nice if all Americans had what most of us take for granted but they don't. Over 62 million Americans don't have access to a primary care provider; eighty percent of ER visits are due to a lack of access to a primary care provider. Telemedicine is a tool that will address the access to care issue, along with providing the citizens and businesses of North Dakota a way to keep healthcare affordable.

I will leave you with three things and then will be glad to answer any questions. First, there are only two other states who have enacted legislation similar to what ND is contemplating; those are Arkansas and Delaware. Second, in North Dakota in 2018, Teladoc Health completed over 1500 virtual visits and saved North Dakota companies and employees over $700,000 in healthcare costs. Lastly, our clients in North Dakota include companies such as Cargill, Halliburton, Marathon Petroleum, NTCA Rural Broadband and Tractor Supply and they support an approach that allows for the maximum benefit for telemedicine.

I respectfully ask that you give SB 2094 in its current form a DO PASS recommendation and reject any amendment to restrictive language that removes "store-and-forward technology", which would limit a licensed North Dakota physician's use of all available forms of technology.

Thank you.

#6

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

House Human Services Committee
SB 2094
March 25, 2019

Chairman Weisz and Committee Members, I am Courtney Koebele and represent the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students. NDMA supports SB 2094 for all the reasons stated by the Board of Medicine.

The physician-patient relationship is fundamental to the provision of acceptable medical care. Telemedicine actually has the power to enhance the physician-patient relationship. It is generally accepted that a valid physician-patient relationship must exist before telemedicine services are provided. This relationship can be established in a few different ways:

•A face-to-face examination—an exam utilizing two-way, real-time audio and visual capabilities, like a videoconference—if a face-to-face encounter would be required for the same service in person
•A consultation with another physician who has an ongoing relationship with the patient
•Meeting evidence-based telemedicine practice guidelines developed by major medical specialty societies for establishing a patient-physician relationship

There are exceptions to these steps, such as emergency medical treatment, and on-call or cross coverage situations.

We would like to offer a friendly amendment. Mary Ann Sens, Professor and Chair of Pathology at the UND School of Medicine and Health Sciences, had contacted our office with a suggestion. In order to make this section of the law clear to allow consultations, we offer the following amendment:

Page 2, Line 23 after "consultation" insert" <u>on a diagnosis for a patient to a physician licensed in the state"</u>

It is our understanding that the Board of Medicine has no objection to this amendment. Thank you for the opportunity to testify today. I would be happy to answer any questions.

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Honorable Members of the ND House Human Services Committee:

I am Dr. Mary Ann Sens, a pathologist working and teaching at the University of North Dakota School of Medicine and Health Sciences. I have resided in Grand Forks and held a ND medical license since 2002.

I wish to support an amendment to Senate Bill 2094. Along with the ND Board of Medicine and the ND Medical Association, I strongly support the concept and direction of this legislation and believe it protects North Dakota patients. However, one area needs clarification. In Section 43-17-02.3.3, the concept of "one time consultation" should be clarified by the addition of the highlighted text below:

> ***43-17-02.3. Practice of medicine or osteopathy by holder of permanent, unrestricted license - Exceptions .***
> *The practice of medicine is deemed to occur in the state the patient is located. A practitioner providing medical care to a patient located in this state is subject to the licensing and disciplinary laws of this state and shall possess an active North Dakota license for the practitioner's profession. Notwithstanding anything in this chapter to the contrary, any physician who is the holder of a permanent, unrestricted license to practice medicine or osteopathy in any state or territory of the United States, the District of Columbia, or a province of Canada may practice medicine or osteopathy in this state without first obtaining a license from the North*
> *Dakota board of medicine under one or more of the following circumstances:*
> *1. As a member of an organ harvest team;*
> *2. On board an air ambulance and as a part of its treatment team;*
> *3. To provide one-time consultation* ***on a diagnosis for a patient to a physician licensed in the state*** ***or*** *teaching assistance for a period of not more than seven days; or*
> *4. To provide consultation or teaching assistance previously approved by the board for charitable organizations.*
> ***SECTION 3.*** *Section 43-17-44 .....*

This is important in some areas of medicine, including pathology, but is also applicable to other complex consultations. It is common for pathologists to seek expert consultation on unusual or difficult cases; these consultations between pathologists involve sending slides, lab test results and/or other material to an expert who may be in any state (or country). Some tumors and other conditions are so rare or may require confirmatory testing done only in a few places; it is the standard of care within pathology to seek expert consultation for the best patient care and accurate diagnosis, including those out of state.

At present, the bill stipulates one-time consultation. Does the "one-time" mean that an out-of-state physician can only consult one time to that physician (for a period of seven days) and then never again? That would be the literal interpretation of the provision as it currently reads. This would be a significant deterrent to any physician specialist in another state in consulting with North Dakota physicians.

This amendment makes it clear that "one-time" applies to a particular patient for a particular time. This will allow full utilization of expert specialty consultants for North Dakota patients as deemed appropriate by practicing North Dakota physicians. Although this may intuitively seem the intent of the law and that this situation would be uncommon, it is actually very common in pathology and perhaps other specialties of medicine. This assures diagnostic excellence for North Dakota patients and North Dakota physicians allowing expert consultation when it is needed for diagnosis and treatment options.

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3-25-19

Although I speak from my own specialty because I am most familiar with it, other medical care instances and specialties would benefit from this amendment. Again, to speak from personal knowledge, one of my brothers is struggling with a very aggressive cancer. At a critical decision point in his treatment plan, his oncologist sent my brothers records, scans and pathology to another oncology expert in this particular cancer. Although this expert was out of state, she provided his local oncologist important treatment considerations. This review and tumor board meeting took five days. My brother received consultative care from a world specialist without leaving his local community; the actual treatment occurred within his home community. Note that both these examples of are local, licensed ND physicians reaching out to recognized experts who may not be in ND to get the best care options or diagnosis for a ND patient. With this amendment, my brother's pathologist and oncologist are free to utilize this consultation again on another patient or on my brother as his disease evolves over time and treatment.

This allows delivery of optimal medical care within the state and strong support for practicing and licensed ND physicians

Respectfully,

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SB 2094
AH 1
March 28-19

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2094

Page 1, line 2, after the semi-colon insert "to create and enact section 43-62-14.1, relating to fluoroscopy technologists;"

Page 6, line 12, after the period insert:

"**SECTION 6.** Section 43-62-14.1 of the North Dakota Century Code is created and enacted as follows:

43-62-14.1. Fluoroscopy technologist.

1. The board shall automatically issue a license to an individual currently licensed or permitted in good standing by the North Dakota board of medicine to practice as a fluoroscopy technologist as of August 1, 2019.
2. A fluoroscopy technologist may only perform the following fluoroscopic procedures in North Dakota:
   a. Gastrointestinal fluoroscopy of the esophagus;
   b. Stomach; and
   c. Small and large intestine.
3. A fluoroscopy technologist may not provide fluoroscopy services except under the supervision of a primary supervising physician.
4. In circumstances in which a fluoroscopy technologist performs fluoroscopy procedures outside the presence of the fluoroscopy technologist's primary supervising physician, the fluoroscopy technologist must be supervised by an onsite supervising physician who is immediately available to the fluoroscopy technologist for consultation and supervision at all times when the fluoroscopy technologist is performing fluoroscopy procedures.
5. A supervising physician may not designate the fluoroscopy technologist to take over the physician's duties or cover the physician's practice. During any absence or temporary disability of a primary supervising physician, the fluoroscopy technologist will be responsible to the substitute primary supervising physician.
6. A licensee under this section shall be subject to disciplinary action by the board pursuant to section 43-62-19.
7. Evidence that the licensee has completed at least six hours of fluoroscopy safety and relevant radiation protection continuing education and a copy of the agreement with a primary supervising physician shall be submitted to the board biannually with radiography license renewal."

Renumber accordingly

SB 2094
4/15/19
#1 pg. 1

19.8055.02004
Title.

Prepared by the Legislative Council staff for
Senator J. Lee

April 5, 2019

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2094

That the House recede from its amendments as printed on pages 1263-1269 of the Senate Journal and pages 1466-1472 of the House Journal and that Engrossed Senate Bill No. 2094 be amended as follows:

Page 1, line 1, replace the second "and" with a comma

Page 1, line 1, after "43-17-45" insert ", and 43-62-14.1"

Page 1, line 2, after "telemedicine" insert "and the regulation of fluoroscopy technologists"

Page 1, line 2, remove the first "and"

Page 1, line 3, after "43-17-01" insert ", 43-17-02,"

Page 1, line 3, after "43-17-02.3" insert ", subsection 1 of section 43-17.1-02, and sections 43-17.1-05, 43-17.1-05.1, and 43-17.1-06"

Page 1, line 4, replace the second "and" with a comma

Page 1, line 4, after the second "medicine" insert ", and the regulation of fluoroscopy technologists; to provide a penalty; and to provide for application"

Page 2, after line 8, insert:

"**SECTION 2. AMENDMENT.** Section 43-17-02 of the North Dakota Century Code is amended and reenacted as follows:

43-17-02. Persons exempt from the provisions of chapter.

The provisions of this chapter do not apply to the following:

1. Students of medicine or osteopathy who are continuing their training and performing the duties of a resident in any hospital or institution maintained and operated by the state, an agency of the federal government, or in any residency program accredited by the accreditation council on graduate medical education, provided that the North Dakota board of medicine may adopt rules relating to the licensure, fees, qualifications, activities, scope of practice, and discipline of such persons.

2. The domestic administration of family remedies.

3. Dentists practicing their profession when properly licensed.

4. Optometrists practicing their profession when properly licensed.

5. The practice of christian science or other religious tenets or religious rules or ceremonies as a form of religious worship, devotion, or healing, if the person administering, making use of, assisting in, or prescribing, such religious worship, devotion, or healing does not prescribe or administer drugs or medicines and does not perform surgical or physical operations, and if the person does not hold out to be a physician or surgeon.

6. Commissioned medical officers of the armed forces of the United States, the United States public health service, and medical officers of the veterans administration of the United States, in the discharge of their official duties, and licensed physicians from other states or territories if called in consultation with a person licensed to practice medicine in this state.

7. Doctors of chiropractic duly licensed to practice in this state pursuant to the statutes regulating such profession.

8. Podiatrists practicing their profession when properly licensed.

9. Any person rendering services as a physician assistant, if such service is rendered under the supervision, control, and responsibility of a licensed physician. However, sections 43-17-02.1 and 43-17-02.2 do apply to physician assistants. The North Dakota board of medicine shall prescribe rules governing the conduct, licensure, fees, qualifications, discipline, activities, and supervision of physician assistants. Physician assistants may not be authorized to perform any services which must be performed by persons licensed pursuant to chapters 43-12.1, 43-13, 43-15, and 43-28 or services otherwise regulated by licensing laws, notwithstanding the fact that medical doctors need not be licensed specifically to perform the services contemplated under such chapters or licensing laws.

10. A nurse practicing the nurse's profession when properly licensed by the North Dakota board of nursing.

11. ~~A person rendering fluoroscopy services as a radiologic technologist if the service is rendered under the supervision, control, and responsibility of a licensed physician and provided that the North Dakota board of medicine prescribes rules governing the conduct, permits, fees, qualifications, activities, discipline, and supervision of radiologic technologists who provide those services.~~

~~12.~~ A naturopath duly licensed to practice in this state pursuant to the statutes regulating such profession.

~~13.~~12. An individual duly licensed to practice medical imaging or radiation therapy in this state under chapter 43-62.

~~14.~~13. An acupuncturist duly licensed to practice in this state pursuant to the statutes regulating such profession."

Page 2, line 23, after "consultation" insert "on a diagnosis for a patient to a physician licensed in the state,"

Page 3, line 10, replace "valid" with "bona fide"

Page 4, after line 23, insert:

"**SECTION 6. AMENDMENT.** Subsection 1 of section 43-17.1-02 of the North Dakota Century Code is amended and reenacted as follows:

1. For the purpose of investigating complaints or other information that might give rise to a disciplinary proceeding against a physician~~, a~~ or physician

assistant~~, or a fluoroscopy technologist~~, the president of the board ~~must~~shall designate two investigative panels, each ~~comprised~~composed of six members of the board. Five members of each panel must be physician members of the board. One member of each panel must be a public member of the board.

SECTION 7. AMENDMENT. Section 43-17.1-05 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-05. Complaints.

1. Any person may make or refer written complaints to the investigative panels with reference to the acts, activities, or qualifications of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ licensed to practice in this state, or to request that an investigative panel review the qualifications of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ to continue to practice in this state. Any person ~~who~~that, in good faith, makes a report to the investigative panels under this section is not subject to civil liability for making the report. For purposes of any civil proceeding, the good faith of any person ~~who~~that makes a report pursuant to this section is presumed. Upon receipt of any complaint or request, the investigative panel shall conduct the investigation as ~~it~~the panel deems necessary to determine whether any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ has committed any of the grounds for disciplinary action provided for by law. Upon completion of ~~its~~the investigation of the investigative panel, the investigative panel shall make a finding that the investigation discloses that:

   a. There is insufficient evidence to warrant further action;

   b. The conduct of the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ does not warrant further proceedings but the investigative panel determines ~~that~~ possible errant conduct occurred that could lead to significant consequences if not corrected. In such a case, a confidential letter of concern may be sent to the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~; or

   c. The conduct of the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ indicates ~~that~~ the physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ may have committed any of the grounds for disciplinary action provided for by law and which warrants further proceedings.

2. If the investigative panel determines ~~that~~ a formal hearing should be held to determine whether any licensed physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ has committed any of the grounds for disciplinary action provided for by law, ~~it~~the panel shall inform the respondent physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ involved of the specific charges to be considered by serving upon that ~~person~~individual a copy of a formal complaint filed with the board for disposition pursuant to the provisions of chapter 28-32. The board members who have served on the investigative panel may not participate in any proceeding before the board relating to ~~said~~the complaint. The complaint must be prosecuted before the board by the attorney general or one of the attorney general's assistants.

3. If an investigative panel finds ~~that~~ there are insufficient facts to warrant further investigation or action, the complaint must be dismissed and the matter is closed. The investigative panel shall provide written notice to the ~~individual or entity~~person filing the original complaint and the ~~person~~individual who is the subject of the complaint of the investigative panel's final action or recommendations, if any, concerning the complaint.

SECTION 8. AMENDMENT. Section 43-17.1-05.1 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-05.1. Reporting requirements - Penalty.

1. A physician, a physician assistant~~, or a fluoroscopy technologist~~, a health care institution in the state, a state agency, or a law enforcement agency in the state having actual knowledge that a licensed physician~~, a~~ or physician assistant~~, or a fluoroscopy technologist~~ may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board promptly shall ~~promptly~~ report that information in writing to the investigative panel of the board. A medical licensee or any institution from which the medical licensee voluntarily resigns or voluntarily limits the licensee's staff privileges shall report that licensee's action to the investigative panel of the board if that action occurs while the licensee is under formal or informal investigation by the institution or a committee of the institution for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment.

2. Upon receiving a report concerning a licensee an investigative panel shall, or on its own motion an investigative panel may, investigate any evidence that appears to show a licensee is or may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board.

3. A person required to report under this section ~~who~~that makes a report in good faith is not subject to criminal prosecution or civil liability for making the report. For purposes of any civil proceeding, the good faith of any person ~~who~~that makes a report pursuant to this section is presumed. A physician who obtains information in the course of a physician-patient relationship in which the patient is another physician is not required to report if the treating physician successfully counsels the other physician to limit or withdraw from practice to the extent required by the impairment. A physician who obtains information in the course of a professional peer review pursuant to chapter 23-34 is not required to report pursuant to this section. A physician who does not report information obtained in a professional peer review is not subject to criminal prosecution or civil liability for not making a report. For purposes of this section, a person has actual knowledge if that person acquired the information by personal observation or under circumstances that cause that person to believe there exists a substantial likelihood that the information is correct.

4. An agency or health care institution that violates this section is guilty of a class B misdemeanor. A physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ who violates this section is subject to administrative action by the board as specified by law or by administrative rule.

SECTION 9. AMENDMENT. Section 43-17.1-06 of the North Dakota Century Code is amended and reenacted as follows:

43-17.1-06. Powers of the board's investigative panels.

The board's investigative panels may:

1. Subpoena witnesses and physician and hospital records relating to the practice of any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ under investigation. The confidentiality of the records by any other statute or law does not affect the validity of an investigative panel's subpoena nor the admissibility of the records in board proceedings; however, the proceedings and records of a committee ~~that~~which are exempt from subpoena, discovery, or introduction into evidence under chapter 23-34 are not subject to this subsection.

2. Hold preliminary hearings.

3. Upon probable cause, require any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ under investigation to submit to a physical, psychiatric, or competency examination or chemical dependency evaluation.

4. Appoint special masters to conduct preliminary hearings.

5. Employ independent investigators ~~when~~if necessary.

6. Hold confidential conferences with any complainant or any physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ with respect to any complaint.

7. File a formal complaint against any licensed physician~~,~~ or physician assistant~~, or fluoroscopy technologist~~ with the board.

SECTION 10. Section 43-62-14.1 of the North Dakota Century Code is created and enacted as follows:

43-62-14.1. Fluoroscopy technologist.

1. Effective August 1, 2019, an individual licensed or permitted as a fluoroscopy technologist by the North Dakota board of medicine who is in good standing on that date, automatically becomes licensed as a fluoroscopy technologist by the North Dakota medical imaging and radiation therapy board.

   a. Effective August 1, 2019, the North Dakota board of medicine shall revoke every active fluoroscopy technologists license issued by that board.

   b. Effective August 1, 2019, the North Dakota medical imaging and radiation therapy board shall issue a fluoroscopy technologist license to every individual qualified under this subsection to be automatically licensed.

2. The scope of practice of a licensed fluoroscopy technologist is limited to gastrointestinal fluoroscopy of the esophagus, stomach, and small and large intestines.

3. Fluoroscopy services provided by a licensed fluoroscopy technologist must be provided under the supervision of a primary supervising physician.

4. If a fluoroscopy technologist performs a fluoroscopy procedure outside the presence of the technologist's primary supervising physician, the technologist must be supervised by an onsite supervising physician who is immediately available to the technologist for consultation and supervision at all times the technologist is performing a fluoroscopy procedure.

5. Under this section, a supervising physician may not designate the fluoroscopy technologist to take over the physician's duties or cover the physician's practice. During an absence or temporary disability of a primary supervising physician, the fluoroscopy technologist is responsible to the substitute primary supervising physician.

6. To qualify for biennial license renewal, a fluoroscopy technologist shall submit to the board with radiography license renewal:

   a. Evidence of completion of at least six hours of continuing education on fluoroscopy safety and relevant radiation protection; and

   b. A copy of an agreement with a primary supervising physician.

7. A licensee under this section is subject to the disciplinary authority of the board under section 43-62-19.

SECTION 11. APPLICATION. To facilitate application of sections 2 and 6 through 10 of this Act, the North Dakota board of medicine shall provide the North Dakota medical imaging and radiation therapy board with the files regarding all active fluoroscopy technologists licensed by the North Dakota board of medicine necessary for the North Dakota medical imaging and radiation therapy board to take over licensure and regulation of these technologists."

Renumber accordingly