February 28, 2020

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Via email to Brint.Carlton@tmb.state.tx.us, Szaafran@gmail.com, Scott.Freshour@tmb.state.tx.us

Re: Joint comments on topics discussed at February 18, 2020 TMB Opioid Workgroup

Dear Messrs.,

On behalf of the Texas Medical Association, the Texas College of Emergency Physicians, the Texas Orthopaedic Association, and the Texas Academy of Family Physicians (collectively, the Healthcare Organizations), we appreciate the opportunity to provide feedback on the Texas Medical Board's (the Board) Opioid Workgroup meeting held February 18, 2020. Collectively, the Healthcare Organizations represent more than 53,000 Texas physicians and medical students. As organizations that supports Texas's physicians, the Healthcare Organizations have great interest in these issues.

We thank the Board for continuing to seek feedback from relevant organizations before implementing the recent unclear legislation on opioids. In general, we support the Board's direction so far and applaud the Board for taking the initiative to provide guidance on these issues. We would specifically like to thank the Board for the prompt publication of the updated Prescription Monitoring Drug Program guidance relating to H.B. 2561 85(R) and H.B. 3284 86(R) following the workgroup meeting. The Board's guidance remedied the concerns discussed at that meeting on that issue and appropriately captured the intent of the legislature.

We have just a few final concerns we would like to reiterate to the Board, which were also addressed in the previous workgroup meetings. Please note we continue to reserve the right to amend or add to our comments as the rulemaking process proceeds.

COMMENTS

1. 10-Day Opioid Prescriptions for Acute Pain: Representatives from the Board expressed concern that a telephone call was not an appropriate means to assess a patient for a subsequent opioid prescription for

acute pain after the initial 10-day opioid prescription. Instead, it appeared that the Board wanted to limit the form of assessment for a follow-up opioid prescription to treat acute pain to an in-person visit or a synchronous audiovisual communication. There was also concern that permitting a communication like a telephone call may run afoul of the Ryan Haight Act. However, we contend that these concerns are unfounded for the following reasons:

First, in the applicable definition of "telemedicine medical service," the Texas Legislature broadly defined the means of a "telemedicine medical service" as entailing the use of any "telecommunications or information technology."[1] This includes a telephone call. And the statute recognizes that such telecommunication is capable of meeting the standard of care for a subsequent opioid prescription to treat acute pain where there is a pre-existing, valid physician-patient relationship.

Section 111.007 provides the standard of care:

> A health professional providing a health care service or procedure as a telemedicine medical service or a telehealth service is subject to the standard of care that would apply to the provision of the same health care service or procedure in an in-person setting.

Section 111.005(a) provides that a valid practitioner-patient relationship is present when the practitioner (a) *has a preexisting relationship with the patient*; (b) communicates, regardless of the means, under a call coverage agreement; or (c) communicates using either synchronous audiovisual interaction, asynchronous store and forward technology, or "another form of audiovisual telecommunication technology that allows the practitioner to comply with the standard of care."

Therefore, the statute allows a physician to use his or her judgment to determine whether a telecommunication, including a telephone call, would meet the standard of care to assess whether a preexisting patient may need a subsequent opioid prescription to treat acute pain. And this makes sense. While some post-operative assessments may require an in-person examination, others may not. For example, pain associated with a vaginal delivery may not need a visual inspection for the physician to determine whether another 10-day opioid prescription may be appropriate to manage acute pain. And generally patients who have undergone a procedure have a scheduled two-to-six week inpatient post-operative follow up, which curbs the concerns for potential prescription abuse.

If the Board intends to promulgate rules that would restrict the means of telecommunication for a subsequent opioid prescription to treat acute pain where there is a pre-existing physician-patient relationship, it would create a higher standard of care, which undermines the plain language of the statute:

> An agency with regulatory authority over a health professional may not adopt rules pertaining to telemedicine medical services or telehealth services that would impose a higher standard of care than…that [which] would apply to the provision of the same health care service or procedure in an in-person setting.

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[1] Section 111.001 of the Texas Occupations Code defines "telemedicine medical service" as:

> [A] health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Tex. Occ. Code § 111.007(a)-(b).

Second, permitting a physician to use his or her judgment in this manner when he or she has a preexisting relationship with their patient also aligns with the Ryan Haight Act. The Act is not a bright-line rule against prescribing controlled substances. Instead, it permits a physician to do so if the physician has conducted at least one in-person assessment of the patient or complies with one of the telemedicine exceptions under the Act. Therefore, recognizing a telephone call as an appropriate telecommunication for a subsequent opioid prescription to treat acute pain for a patient with a pre-existing physician-patient relationship does not run afoul of the Act.

Third, limiting post-operative follow-up for a subsequent opioid prescription to treat acute pain to only an in-person visit or a synchronous audiovisual communication puts an unfair burden on the patient. As stated in the meeting, it may be inconvenient, painful, or even harmful for the patient, who has just undergone a painful procedure, to have to travel during his or her post-operative recovery to meet with his or her physician for an in-person visit. And to the extent the Board limits telemedicine to just a synchronous audiovisual communication, it puts the burden on the patient to find a physician with this form of telecommunication support. Further, the synchronous audiovisual communication requirement may isolate rural patients who have limited to no broadband support.

Fourth and finally, as a practical matter, the Board's focus on the means of communication, while well-intentioned, misses the mark. The focus should not be on the *means* of contact, but instead should focus on a ***meaningful*** contact. What will be meaningful in one situation may not be in another. But all assessments for a subsequent opioid prescription should be meaningful, whether it is day 5 or day 11. And this should be left to the physician's proper medical judgment based on the physician's relationship with the patient and individual treatment plan, and in accordance with the standard of care.

2. Continuing Medical Education (CME): We appreciate the progress made by the Board relating to the confusing legislation on the opioid CME requirements. We agree with the Board that only two hours is required, and we thank the Board for considering a look-back period in the rulemaking process to capture those licenses up for renewal prior to rules being finalized. It is important to include an exception for these upcoming license renewals because there is no guidance for these individuals on compliance with the new laws—which even for those with legal backgrounds, proved to be confusing. An exception is important to ensure these individuals are not found noncompliant due to the time gap in the law's effective date and promulgation of corresponding rules.

Additionally, we reiterate two points from our previous letter and urge the Board to implement our recommendations: First, we ask the Board to appropriately tailor its rules to the specified physicians in the bills—prescribers and direct patient-care physicians. The legislature identified those individuals as being the ones on the front line to help battle the opioid crisis. This also prevents physicians who do not prescribe or interact with direct-care patients from wasting valuable time on CME that may not be relevant to their practice. Second, we urge the Board to clarify that those required to take the CME do not have to take the *same* course each time for the purpose of compliance. Taking the same course each time will hinder physicians from staying up-to-date on new issues and pain management methods, consequently undermining the legislative intent of the law.

CONCLUSION

We thank the Board for this opportunity to provide feedback relating to the Board's Opioid Workgroup meeting. If you have any questions, please do not hesitate to contact any of the following TMA staff at TMA's main number, 512-370-1300, or by email: Rocky Wilcox, Vice President and General Counsel, at rocky.wilcox@texmed.org; Kelly Walla, Associate Vice President and Deputy General Counsel, at

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Sincerely,

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