Assessment of Public Comment

During the public comment period, the Board received approximately 66 unique written comments, and two comments after the public comment period ended.

The Board received several comments from individuals, providers, and societies expressing concerns that the proposal was too restrictive and objecting to requiring an in-person visit appointment every third visit. In response to these comments, the Board has moved the entire proposal to section 324.2 of Title 12, and added language explicitly making clear that a prior authorization request may be made to deviate from any of the rules in the proposal, including the requirement that every third encounter be in person. The Board recognizes that there are situations where deviations from the general telehealth requirements may be warranted, such as rural patients or other patients with a lack of access to providers close by (or providers of the type they need, such as behavioral health providers), patients with severe psychological problems that may prevent them from attending an in-person appointment, etc.

One comment expressed concern as to how the Board could enforce every third encounter. Carriers are able to identify by modifier listed on a medical bill whether the treatment occurred via telehealth. Thus, when treatment does not adhere to the rules regarding in-person visits and the provider has failed to secure prior authorization for telehealth, the carrier may object to the medical bill. Therefore, no change has been made in response to this comment.

One comment requested clarification about what constitutes an initial in-person clinical encounter. The Board has added clarifying language to the proposal that the initial in-person encounter must be with a Board-authorized provider.

The Board received a comment from a patient supporting the adoption of a permanent telehealth proposal. The Board also received a comment from a physician supporting the proposal’s permanent adoption. No change has been made in response to these comments.

The Board received one comment from a provider opining that using modifiers in the proposal is confusing and requested the addition of several codes instead, and one comment from a company also requesting clarification. The Board has clarified the language surrounding when to use each modifier.

The Board received one comment from a provider requesting the proposal be changed to explicitly disallow orthopedic evaluations to be done via telehealth. Because the proposal does not require any provider perform any evaluations via telehealth, the Board believes in some cases telehealth may be appropriate, no change has been made in response to this comment.

One comment from a company requested that the Board permanently adopt the emergency telemedicine adoption. Because that proposal deals more with concerns about COVID-19, and the Board has made substantial revisions to this proposal, the Board is not proposing identical text to the emergency adoption.
The Board received two comments expressing concern with the language in the proposal stating that remote intra-operative monitoring cannot be performed by telehealth, opining that this raises issues because this is routine for most brain and spine operations and it will be virtually impossible to find providers willing to do these surgeries and another comment requesting clarification about this in regards to the CPT codes. The Board also received several comments opining that the proposal is “absurd” and opining that intraoperative monitoring via telehealth is necessary. The Board has not made any changes in response to these comments, because the Board believes best practice currently is not to allow this type of monitoring via telehealth.

Two comments expressed concern with requiring that in order to see a patient via telehealth, that provider must have seen the patient at the initial in-person encounter. While the Board believes this is best practice, it is possible in some circumstances that medical necessity dictates a different provider follow up, and in that case a prior authorization request could be made to deviate from the rules in the proposal, and the Board has added language to the proposal clearly indicating such a request may be made.

The Board received several comments opining that physical therapy should be permitted via telehealth and two other comments opining that occupational therapy and chiropractic treatment should also be available via telehealth. Given the physical nature of physical therapy and chiropractic treatment, the Board has not made any changes specifically in response to this comment, but notes that a provider may request prior authorization for treatment via telehealth when there is a medical justification for treatment via telehealth.

One comment expressed support for not allowing telehealth treatment by physical therapists, occupational therapists, acupuncturists and chiropractors, as well as support for not allowing permanency evaluations via telehealth. No change has been made in response to this comment.

The Board received one comment requesting clarification about whether permanency evaluations not being allowed via telehealth is related to maximum medical improvement or permanent impairment evaluation. Not allowing permanency evaluations to telehealth is related both to maximum medical improvement and permanent impairment evaluation, and no change has been made in response to this comment.

The Board received two comments supporting the inclusion of two-way treatment and care via telephone, and no change has been made in response to this comment.

The Board received two comments requesting that the proposal be amended to include a requirement that telehealth services be reimbursed on the same basis, at the same rate, and to the same extent as if the treatment was in-person. The proposal does not provide for modified fees when a treatment is rendered via telehealth. Accordingly, no change has been made as a result of this comment.

One comment requested clarification about how “medically appropriate” is defined, as convenience does not appear to be a valid reason for a telehealth visit under the proposal. “Medically appropriate” refers to a clinical determination that something is or is not consistent
with medical standards of care, and not whether something is merely more or less convenient for the participants, and no change has been made in response to this comment.

The Board received a comment from an individual requesting a longer public comment period because they just only heard about the proposal close to the closing of the public comment period. Because the Board issued a Subject Number announcing the proposal, posted the proposal on its website, and the proposal was published in the State Register and open for a 60-day public comment period, no change has been made in response to this comment.

**Independent Medical Exam (IME) concerns**

The Board received several comments opining that IMEs are not suitable for telehealth in any circumstances, for concerns about privacy, quality, and parity among other reasons. The proposal does not require any IMEs to be performed by telehealth and are only available in very limited circumstances when medically appropriate. Additionally, all parties have to agree in order for an IME to be formed via telehealth. Therefore, no change has been made in response to these comments.

One comment from an association also opined that the proposal should add language that when a claimant elects to be treated via telehealth, they also consent to a concomitant IME via telehealth by the carrier or self-insured employer. Because IMEs are completely different under the Workers’ Compensation Law and handled separately from treatment, no change has been made in response to this comment.

**Changes made:**
- Moved entire proposal to 324.2
- Added language to (g)(1) to clarify that the initial in-person encounter must be with a Board-authorized provider
- Changed language in (g)(1)(iii) to clarify that a provider providing telehealth services must have previously done an in-person assessment
- Added language to (g)(1)(ix) to further make clear that IMEs are not required to be conducted via telehealth
- Added clarifying language to (g)(1)(x) to make it explicitly clear that remote intraoperative monitoring is not a telehealth service and is not permitted by this proposal
- Added language to (g)(1)(xii) to clarify when to use which modifiers
- Added subdivision (g)(2) to make clear that a prior authorization request can be made to deviate from any of the rules in the proposal